

AMENDED **FILED JUL 25 1961** Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6530**

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 25 yrs		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Hos		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 3969 Ashland Ave		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle L. Last Williams			4. DATE OF DEATH Month 7 Day 13 Year 61						
5. SEX Male	6. COLOR OR RACE Col.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH II/15/09	9. AGE (last birthday) 51	IF UNDER 1 YEAR Months 28 Days	IF UNDER 24 HR Hours 28 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Corinth, Miss,		12. CITIZEN OF WHAT COUNTRY USA.			
13a. FATHER'S NAME Samuel Williams			13b. MOTHER'S MAIDEN NAME Lillian Lacy			14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give yrs or dates of service) yes			17. INFORMANT Address Mable Tolston Martin 3969 Ashland Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest; Contrib: acute Diffuse Peritonitis due to acute perforated gastric ulcer; while undergoing operation (ulcers) at Homer G Phillips Hospital on July 13, 1961									INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b)			DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 570.1						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See above							
20c. TIME OF INJURY Hour ? a.m. / p.m. Month, Day, Year 7-13-61		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, hgh., etc.) Hospital		20f. CITY, TOWN, OR LOCATION St. Louis, Mo		COUNTY STATE	
21. I attended the deceased from 12:03 to 12:03 and last saw her/him alive on 7-13-61 Death occurred at 12:03 on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Joseph M. [Signature] (Degree or title)				22b. ADDRESS 1300 Clark			22c. DATE SIGNED 7-14-61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/17/61	23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) Jeff. Bks, Mo.			(State)	
24. FUNERAL DIRECTOR Wright Funeral Home 3100 Easton Ave. ADDRESS				25. DATE RECD. BY LOCAL REG. JUL 14 1961		26. REGISTRAR'S SIGNATURE Lead Smith, M.D.			

STATE FILE NUMBER

has deceased lived in institution, Residence before admission) P. COUNTY

Reside on farm	Yes <input type="checkbox"/> No <input type="checkbox"/>
(If outside, give location)	
Reside in city	Yes <input type="checkbox"/> No <input type="checkbox"/>

Yes No

DATE OF DEATH

DECEASED'S NAME

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Arthur L. Heulward

Licensed Embalmer No. 42201

P. O. Address 3100 Easton Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body, is not embalmed, fact should be so stated above.