

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 218 Primary Registration District No. 1003 Registrar's No. 7932 STATE FILE NUMBER -61-031225

FILED SEP 6 1961

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1212a Armstrong</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Williams</u> Last <u>Williams</u>			4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>61</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/21/1905</u>	9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Montocello, Georgia</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Lee Digby</u>		13b. MOTHER'S MAIDEN NAME <u>Lithan Blackwell</u>		14. NAME OF HUSBAND OR WIFE <u>Alex Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			17. INFORMANT Address <u>Minnie Favors 1222 A. Armstrong</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Arteriosclerotic heart disease</u>					
DUE TO (c) <u>420.0</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Uterine Leiomyoma</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input 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.)			
20c. TIME OF INJURY Hour <u>9:30</u> Month, Day, Year <u>8-15-61</u> a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Lemay, Missouri</u>		STATE
21. I attended the deceased from <u>8-15-61</u> to <u>8-21-61</u> and last saw her ^{her} alive on <u>8-21-61</u> Death occurred at <u>9:30</u> p. m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Rosal Copp J. M.D.</u>			22b. ADDRESS <u>2601 N. Whittier St.</u>		22c. DATE SIGNED <u>8-23-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8/28/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakdale Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lemay, Missouri</u>	
24. FUNERAL DIRECTOR <u>E. B. Hoover</u>		ADDRESS <u>1221 N. Grand</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 25 1961</u>	26. REGISTRAR'S SIGNATURE <u>Rosal Smith, M.D.</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

DATE AMENDED

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Malvin Blockman

Licensed Embalmer No. 3462

P. O. Address 1221 N. Swan

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.