

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9002** STATE FILE NUMBER

1. PLACE OF DEATH
 a. COUNTY
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Length of stay in ib **2 mo. 1 wk.**
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Chronic Hosp.** Inside Limits Yes No
 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Mo.** b. COUNTY
 c. CITY OR TOWN **St. Louis** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **3955a Evans Ave.** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First **Matilda** Middle Last **Williams** 4. DATE OF DEATH Month **9** Day **28** Year **1961**

5. SEX **Female** 6. COLOR OR RACE **Col.** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **1-28-1881** 9. AGE (last birthday) **80** IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Nil** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (City and state or country) **Newbern, Alabama** 12. CITIZEN OF WHAT COUNTRY **U.S.A**

13a. FATHER'S NAME **John Bryant** 13b. MOTHER'S MAIDEN NAME **Unk.** 14. NAME OF HUSBAND OR WIFE **Dead**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **None** 17. INFORMANT **Marian Wesley** Address **3955 a. Evans 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) **Glomerulonephritis, chronic** INTERVAL BETWEEN ONSET AND DEATH **5 Years**
 DUE TO (b)
 DUE TO (c) **592x**
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **ANEMIA - MALNUTRITION - DECUBITUS ULCERS** PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **7-11-61** to **9-28-61** and last saw her/him alive on **9-28-61**
 Death occurred at **2:25 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **John J Keensy MD** (Degree or title) 22b. ADDRESS **5800 Arsenal Ave** 22c. DATE SIGNED **9-28-61**

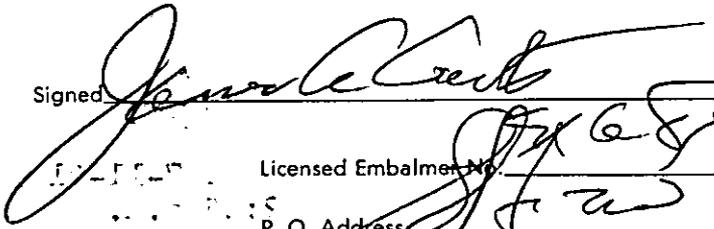
23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal (Motor)** 23b. DATE **10/3/61** 23c. NAME OF CEMETERY OR CREMATORY **Booker Washington Cem.** 23d. LOCATION (City, town, or county) (State) **Centerville Ill**

24. FUNERAL DIRECTOR ADDRESS **C.W. Roberts Und.Co 1416 N.Taylor Ave** 25. DATE RECD. BY LOCAL REG. **SEP 29 1961** 26. REGISTRAR'S SIGNATURE **Earl Smith, M.D.**

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  _____
Licensed Embalmer No. _____
P. O. Address _____

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.