SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

MENT OF PUBLIC HEALTH AND WELFARE

-61-039393

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10372

FILED NOV 15 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1515 Rear Franklin
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Floyd Middle: Last: Williams

4. DATE OF DEATH: Month 11 Day 7 Year 61

5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 5-28-13
9. AGE (last birthday): 48
IF UNDER 1 YEAR: Months 5 Days 11
IF UNDER 24 HR: Hours 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): St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A

13a. FATHER'S NAME: Albert Williams
13b. MOTHER'S MAIDEN NAME: Annie Johnson
14. NAME OF HUSBAND OR WIFE: Beatrice Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.
17. INFORMANT: Bessie Gaines
Address: 3113 Cass

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable Brain Tumor, Etiology Unknown — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 237X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

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 11-4-61 to 11-7-61 and last saw him alive on 11-7-61
Death occurred at 3:25 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Sydney R. Frazier (Degree or title) M. D.
22b. ADDRESS: 2601 N. Whittier Street
22c. DATE SIGNED: 11-7-61

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 11-13-61
23c. NAME OF CEMETERY OR CREMATORY: NATIONAL CEM.
23d. LOCATION (City, town, or county): JEFFERSON BK. (State): MO.

24. FUNERAL DIRECTOR: WALTON
ADDRESS: 2707 Stoddard
25. DATE RECD. BY LOCAL REG.: NOV 8 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

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_____ Signed W. Claude Gordon

Signature of Student Embalmer

Licensed Embalmer No. 3489

P. O. Address 1123 N. Taylo

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.