

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004314

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 277

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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STATE AMENDED

INSTEAD OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY FILED JAN 17 1963		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 35 yrs.	c. CITY OR TOWN St. Louis
c. FULL NAME OF (IF NOT IN hospital, give location) HOSPITAL OR INSTITUTION 1404 Belt Ave.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1404 Belt Ave.
3. NAME OF DECEASED (Type or print) First THOMAS Middle WILLIAMS Last		4. DATE OF DEATH Month Jan. Day 7, Year 1963	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/6/08
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Granite City Steel-Minter City, Miss.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Patrick Williams		13b. MOTHER'S MAIDEN NAME Carrie Cooper	14. NAME OF HUSBAND OR WIFE Ethel Mae Williams
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. 93	17. INFORMANT Address Ethel Mae Williams, 1404 Belt
18. CAUSE OF DEATH (Enter only one cause per item) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO (b) Coronary Heart Disease DUE TO (c) 4201 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 9 Mos
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ s.m. _____ p.m. _____ Month, Day, Year _____	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 COUNTY STATE
21. I attended the deceased from April 7, 1962 , to January 7, 1963 , and last saw her alive on Jan. 7, 1963 . Death occurred at 9 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>E. J. Gates, Jr. M.D.</i>		22b. ADDRESS 2602 N. Union Blvd St. Louis 13, Mo	22c. DATE SIGNED 1/9/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1/12/63	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS Charles J. Gates, Jr., 4107 Finney		25. DATE RECD. BY LOCAL REG. JAN 10 1963	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>

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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 Raymond Dickson Student Embalmer No. 665

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Quinton Swann

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.