

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004315
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 497

FILED JAN 25 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

- 1
- 2 211
- 3
- 4 2
- 5 1
- 6
- 7 1
- 8 1
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- 12 92-3
- 13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Missouri</u>		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) <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) <u>DOA Homer G. Phillips</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4363 N. Market</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Tilford Williams</u>		First <u>Tilford</u> Middle <u>Williams</u> Last	4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/31/89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (last birthday) <u>73</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HR: Hours Min.
11a. BIRTHPLACE (City and state or country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Tilford Williams</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline Williams</u>	14. NAME OF HUSBAND OR WIFE <u>Safronia Adams</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or Not known) (If yes, give year or dates)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Safronia Williams 4363 N. Market</u>
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage;</u> DUE TO (b) <u>Atherosclerosis.</u> DUE TO (c) <u>331x</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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. <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 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> </u> Month, Day, Year 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	COUNTY STATE
21. I attended the deceased from <u> </u> to <u> </u> and last saw her alive on <u> </u> . Death occurred at <u> </u> <u>4:30 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Joseph M. Dickson</u> (Degree or title) <u>Deputy</u>		22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>1-15-63</u>
23a. BURIAL, CREMATORY, REINTERMENT <u> </u>	23b. DATE <u>1/17/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR <u>B. B. Boone</u>	ADDRESS <u>1221 North Grand</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 16 1963</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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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 _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Dorence Graham

Licensed Embalmer No. 4755

P. O. Address 1221 Green

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.