

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6826**
1746

FILED MAR 5 1949

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

12

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY 1115^a = Aubert Ave		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO	
b. CITY OR TOWN ST. LOUIS		c. CITY OR TOWN ST LOUIS	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1115^a Aubert Ave. D	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1115^a AUBERT			

3. NAME OF DECEASED (Type or Print) MATTIE JEFFERSON WILLIAMS			4. DATE OF DEATH (Month) (Day) (Year) 2 21 1949		
a. (First)	b. (Middle)	c. (Last)	5. SEX F	6. COLOR OR RACE COL.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH 11-21 1895	9. AGE (In years last birthday) 53	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) SUMNER SC. I	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME THOMAS JEFFERSON		13b. MOTHER'S MAIDEN NAME AMYE DAVIS		14. NAME OF HUSBAND OR WIFE THOMAS WILLIAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Thomas Williams ADDRESS 1115^a Aubert	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Secondary Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) acute heart failure			
		DUE TO (c) pneumonia/cetis			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 43.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 705X		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **7-25-1949**, to **2-21-1949**, that I last saw the deceased alive on **2-18-1949**, and that death occurred at **10:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE J. F. Winston, M.D. (Degree or title)		23b. ADDRESS 2743 Franklin		23c. DATE SIGNED 2-23-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 2-24-49		24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PK.	
24d. LOCATION (City, town, or county) ST LOUIS CO		24e. (State) MO		25. FUNERAL DIRECTOR'S SIGNATURE W. J. Walton ADDRESS 2707 Stoddard	
DATE REC'D BY LOCAL REG. FEB 24 1949		REGISTRAR'S SIGNATURE J. B. Fagan			

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.

Signed Arthur L. Hilliard

Signed _____
Student Embalmer

Licensed Embalmer No. 4221

P. O. Address 4049 St Ferdinand

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 this body is not embalmed, fact should be so stated above.