

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21871

State File No.

3871

FILED JUL 15 1949

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY add	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 6 years		d. STREET ADDRESS (If rural, give location) 21- 2819 Gamble St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			
3. NAME OF DECEASED a. (First) Laura b. (Middle) - c. (Last) Williams			4. DATE OF DEATH (Month) (Day) (Year) July 2 1949
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 7-27-1908
9. AGE (In years last birthday) 40		IF UNDER 1 YEAR Months 11	IF UNDER 24 HRS. Days 5 Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Moorehead, Mississippi.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Cy Webster		13b. MOTHER'S MAIDEN NAME Caroline Wade	14. NAME OF HUSBAND OR WIFE Lee 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. --	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lee Williams, 2819 Gamble St.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Purulent Meningitis		INTERVAL BETWEEN ONSET AND DEATH Undet.	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
DUE TO (b) Undetermined		DUE TO (c) None	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) SUICIDE - HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis	
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? 3403	
22. I hereby certify that I attended the deceased from 6-22 , 1949 , to 7-2 , 1949 , that I last saw the deceased alive on 7-2 , 1949 , and that death occurred at 6:45a m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Alvin J. Harrison M.D.		23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 7-5-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-7-1949	24c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri.
DATE REC'D BY LOCAL REG. JUL 6 1949	REGISTRAR'S SIGNATURE J. B. Frazier	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, 2820 Stoddard St.	

(Licensed Embalmer's Statement on Reverse Side)

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

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
Student Embalmer

Signed Lulton E. Culkin

Licensed Embalmer No. 4198

P. O. Address Stennis 137

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.