

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25412

State File No.

6181

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)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Enroute St. Louis City Hospital		d. STREET ADDRESS (If rural, give location) 1120 N. 10th St.	

3. NAME OF DECEASED (Type or Print)	a. (First) Sam	b. (Middle)	c. (Last) Williams	4. DATE OF DEATH (Month) (Day) (Year) 7-10-49
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH About 1884	9. AGE (In years, last birthday) IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min. 65?
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Scanlon, Ark.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Sam Williams	13b. MOTHER'S MAIDEN NAME Martha McCrea	14. NAME OF HUSBAND OR WIFE Lucy Williams
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Martha Reed, Coffeyville, Kansas	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		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) Cerebral Apoplexy		
	DUE TO (c)		
11. 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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) St. Louis
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 234X
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **1:40 P. m.**, from the causes and on the date stated above.

23. SIGNATURE Patrick L. Taylor (Degree or title)	23b. ADDRESS 1300 East	23c. DATE SIGNED 7-15-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-11-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Steele, Mo.
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DATE REC'D BY LOCAL REG. JUL 15 1949	REGISTRAR'S SIGNATURE J. B. Purster	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING 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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. W. Wilkins

Licensed Embalmer No. 3575

P. O. Address St. Louis, Mo.

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.