S. No. 300
. 10.48

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

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318 1003 State File No. 39446

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. 10269

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1948 Dodier

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 1940 Dodier St.

3. NAME OF DECEASED (Type or Print): a. (First) JOHN b. (Middle) c. (Last) WILLIAMS

4. DATE OF DEATH (Month) (Day) (Year): Nov. 27, 1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Dec. 18, 1873
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months 11, Days 14 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Paducah Kentucky
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: John Williams
13b. MOTHER'S MAIDEN NAME: Frances Hubbard
14. NAME OF HUSBAND OR WIFE: KATHRYN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Kathryn Williams — ADDRESS: 1948 Dodier

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Thrombosis
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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): MO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Hospital

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 6:00 P.m., from the causes and on the date stated above.*

23a. SIGNATURE: Patrick E. Taylor (Degree or title): Cor.
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 11-29-49

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 11-30-49
24c. NAME OF CEMETERY OR CREMATORY: BETHANY
24d. LOCATION (City, town, or county) (State): St. Louis MO

DATE REC'D BY LOCAL REGISTRAR: NOV 29 1949
REGISTRAR'S SIGNATURE: J B Fowler
25. FUNERAL DIRECTOR'S SIGNATURE: St. Louis Funeral Home — ADDRESS: 2205 St. Louis Ave

(Licensed Embalmer's Statement on Reverse Side)

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 Elmo P. Padwell

Licensed Embalmer No. 4077

P. O. Address.....

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.