

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17944
State File No. 4742
Registrar's No.

FILED JUN 9 1950

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (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 Homer G Phillips Hospital		e. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2719	
3. NAME OF DECEASED (Type or Print) William		4. DATE OF DEATH (Month) (Day) (Year) May 27 1950	
a. (First)		b. (Middle) Alston	
c. (Last)		5. SEX m	
6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	
8. DATE OF BIRTH 5-27-1892		9. AGE (In years last birthday) 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groom Maker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Brownsville Tenn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Matthews Alston		13b. MOTHER'S MAIDEN NAME Louise Bolton	
14. NAME OF HUSBAND OR WIFE Single		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 Frances Buford	
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, asthma, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Heart Disease DUE TO (c) Hypertension II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH Undet.		19. ADDRESS 2939 Easton Ave	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? HH3X		22. I hereby certify that I attended the deceased from 5-23, 1950, to 5-27, 1950, that I last saw the deceased live on 5-27, 1950, and that death occurred at 10:40pm., from the causes and on the date stated above.	
23a. SIGNATURE James J. Hedrick M. D.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 5-29-50		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 6-2-50		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	
24d. LOCATION (City, town, or county) (State) St Louis Co Mo		25. FUNERAL DIRECTOR'S SIGNATURE Gus Lowe	
25. ADDRESS 2930 Dickson St		DATE REC'D BY LOCAL REG. MAY 29 1950	
REGISTRAR'S SIGNATURE J. B. Lanster		25. ADDRESS	

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.....

working under my personal supervision.

Student Embalmer No.....

Signed Arthur L. Healliard

Signed.....

Student Embalmer

Licensed Embalmer No. 4221

P. O. Address 1249 St Germain

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.