No. 300
10-48

FILED JUN 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22148

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5395

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

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

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: St. Louis,
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, 2119
d. STREET ADDRESS (If rural, give location): 4201 W. Belle

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

4. DATE OF DEATH (Month) June (Day) 18 (Year) 1950

5. SEX: F. 3
6. COLOR OR RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOW V
8. DATE OF BIRTH: 6-15-1878
9. AGE (In years last birthday): 72 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. 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: none
11. BIRTHPLACE (State or foreign country): UNKNOWN 9
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: unk.
13b. MOTHER'S MAIDEN NAME: unk.
14. NAME OF HUSBAND OR WIFE: unk.

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.: none
17. INFORMANT'S SIGNATURE OR NAME: Eula Patton ADDRESS: 4201 W. Belle

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.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Undet.

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

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: None

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 381X

22. *I hereby certify that I attended the deceased from* 6-5, 1950, *to* 6-18, 1950, *that I last saw the deceased alive on* 6-18, 1950, *and that death occurred at* 10:50a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Alvin J. Thomas M. D.
23b. ADDRESS: 2601 N Whittier St
23c. DATE SIGNED: 6-20-50

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 6-24-50
24c. NAME OF CEMETERY OR CREMATORY: Washington P.K. Cem
24d. LOCATION (City, town, or county) (State): 9700 Natval Bridge

DATE REC'D BY LOCAL REG.: Jun 20 1950
REGISTRAR'S SIGNATURE: J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: Herman L Allen ADDRESS: 4368 Washington

(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 _____

_____, working under my personal supervision.

Student Embalmer No. _____

Signed _____
Student Embalmer

Signed J. G. Grear

Licensed Embalmer No. 2963

P. O. Address 4219 Delmar

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.