

FILED NOV 3 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35471  
9107

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	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST Louis</b>		b. COUNTY <b>Mo</b>	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Louis 2259</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1108 N 18th St.</b>		d. STREET ADDRESS (If rural, give location) <b>1315 Carr Rear</b>	

3. NAME OF DECEASED (Type or Print) <b>Moses Willis</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Oct 24 1950</b>		
a. (First)	b. (Middle)	c. (Last)	5. SEX <b>M</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>
8. DATE OF BIRTH <b>Mar 11, 1890</b>	9. AGE (In years less birthday) <b>60</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Miss</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					

13a. FATHER'S NAME <b>Dimple Willie</b>		13b. MOTHER'S MAIDEN NAME <b>Emma</b>		14. NAME OF HUSBAND OR WIFE <b>Margaret Willis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Margaret Willis 1315 Carr Rear</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		<b>arterio Scleroso Cardio Anropsy</b>			
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (c) <b>arterio. Scleroso Cardio Anropsy</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>None known -</b>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	
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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? <b>H2A1</b>	
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22. I hereby certify that I attended the deceased from **9-20**, 19**50**, to **10-27**, 19**50**, that I last saw the deceased alive on **10-27**, 19**50**, and that death occurred at **6 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>B. G. Heron 911 N. O.</b> (Degree or title)		23b. ADDRESS <b>1418 Franklin</b>		23c. DATE SIGNED <b>10-27-50</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>Oct 28/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Clackville</b>		24d. LOCATION (City, town, or county) (State) <b>Miss</b>	
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DATE RECD BY LOCAL REG. <b>Oct 27 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Farnice</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>File Green 4214 Delmar</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*body of [unclear] deceased [unclear]*

**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 *F. G. Green*

02-0

Licensed Embalmer No. *2263*

P.O. Address *4214 [unclear]*

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.