

FILED DEC 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39183

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10204

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. Louis		c. LENGTH OF STAY (in this place)	
c. CITY (If outside corporate limits, write RURAL, and give township) ST. Louis		217.9	
d. FULL NAME OF HOSPITAL OR INSTITUTION FIRMIN Desloge		d. STREET ADDRESS (If rural, give location) 3146 PARK AV.	
3. NAME OF DECEASED (Type or Print) JAMES WILLIAMS		4. DATE OF DEATH (Month) (Day) (Year) NOV 28-50	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH NOV-2-1879
9. AGE (In years last birthday) 71 YRS		# UNDER 1 YEAR Months	# UNDER 1 HOUR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME WILLIAM WILLIAMS	
13b. MOTHER'S MAIDEN NAME MARGARET BIGGER		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 493-10-7383	
17. INFORMANT'S SIGNATURE OR NAME Mrs Laura Gifford		ADDRESS 3146 Park Av	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 1-3 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atherosclerotic Cardiovascular ? years DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia RLL 3 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 4201			
22. I hereby certify that I attended the deceased from Jan 12, 1950, to Nov 21, 1950, that I last saw the deceased alive on Nov 21, 1950, and that death occurred at 6:50 P. M., from the causes and on the date stated above.			
23a. SIGNATURE Robert C. Sweet MD		23b. ADDRESS 504 N. Grand	
23c. DATE SIGNED 11-22-50			
24a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		24b. DATE DEC-1-1950	
24c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. NOV 30 1950		REGISTRAR'S SIGNATURE D. B. Foster	
25. FUNERAL DIRECTOR'S SIGNATURE E. V. Schurer		ADDRESS 3125 Lafayette Av	

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 9 1951

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

Just B. Volmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.