

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 221.9	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2935 Lucas Ave.	

3. NAME OF DECEASED (Type or Print) William			a. (First)			b. (Middle)			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Nov. 5 1951			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug. 15, 1880			9. AGE (In years last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Landers, Mo.				12. CITIZEN OF WHAT COUNTRY?			

13a. FATHER'S NAME Henry Banker			13b. MOTHER'S MAIDEN NAME Lizzy Moore			14. NAME OF HUSBAND OR WIFE Julia Banker					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT'S SIGNATURE OR NAME Julia Banker - 2935 Lucas			ADDRESS		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease with						Undet.	
		ANTECEDENT CAUSES Congestive Failure DUE TO (b) Undetermined							
		DUE TO (c) Gangrene of left foot						Undet.	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 442X	

22. I hereby certify that I attended the deceased from **10-20**, 19**51**, to **11-5**, 19**51**, that I last saw the deceased alive on **11-5**, 19**51**, and that death occurred at **8:35a** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Lawrence W. Harris, M.D.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 11-5-51	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Nov. 13, 1951		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	
DATE REC'D BY LOCAL NOV 9 1951		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		24d. LOCATION (City, town, or county) (State) St. Louis MO.	
25. FUNERAL DIRECTOR'S SIGNATURE English Und. Co.		ADDRESS 2931 Lucas Ave.			

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

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 *AD Richardson*.....

Licensed Embalmer No. *2928*.....

P. O. Address *2625 Glasgow*.....

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.