

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8079

State File No. 1713

FD MAR 11 1955

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).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Missouri	b. COUNTY St. Louis
c. LENGTH OF STAY (in this place) 14 hours		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess hospital		d. STREET ADDRESS (If rural, give location) 455 Appian Drive Lemay 23 Mo.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Edwin	b. (Middle) Dale	c. (Last) Williams	Feb 13 1953		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug 22 1890	9. AGE (In years last birthday) 62	# UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance US Engerning Dept		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Thomas J Williams	13b. MOTHER'S MAIDEN NAME Mary Pritchett	14. NAME OF HUSBAND OR WIFE Florence Williams
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. No	17. INFORMANT'S SIGNATURE OR NAME Lemay MO Florence Williams 455 Appian Dr

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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH undet.
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis, general		
	DUE TO (c) Bronchiectasis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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? 332X

22. I hereby certify that I attended the deceased from **1950**, 19____, to **2/13/53**, 19____, that I last saw the deceased alive on **2/12/53**, 19____, and that ~~the~~ occurred at **2:45A** m., from the causes and on the date stated above.

23a. SIGNATURE Deeann J. G. y 26 O. M. D.	(Degree or title)	23b. ADDRESS 16 Hampton Village Plaza	23c. DATE SIGNED 2/13/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2/16/53	24c. NAME OF CEMETERY OR CREMATORY Fredens Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.

DATE REC'D BY LOCAL REG. FEB 13 1955	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Wm. Schumacher	ADDRESS 3013 Meramec
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

3 21 7 24 . 0 3 .

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 _____

Jack H. Hays

Licensed Embalmer No. *4746*

P. O. Address *St. Louis, Mo.*

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.