

STANDARD CERTIFICATE OF DEATH

State File No. **8083**

BIRTH NO. **60 MAR 11 1953**

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

Registrar's No. **1869**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri 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 2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 1163 Walton	

3. NAME OF DECEASED (Type or Print) Isam		a. (First) Isam	b. (Middle) R.	c. (Last) Williams	4. DATE OF DEATH (Month) (Day) (Year) Feb. 16 1953	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED: NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec. 12 1889	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR: Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME Alexander Williams	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Cassie Williams
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) no	16. SOCIAL SECURITY NO. 486-28-46	17. INFORMANT'S SIGNATURE OR NAME Cassie Williams	ADDRESS 1163 Walton
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	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) Hypertensive Cardiovascular Disease		
	DUE TO (c) Undetermined		
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 <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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 443 X
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22. I hereby certify that I attended the deceased from **2-12**, 19**53**, to **2-16**, 19**53**, that I last saw the deceased alive on **2-16**, 19**53**, and that death occurred at **3:55 am.**, from the causes and on the date stated above.

23a. SIGNATURE Edward B. Williams M.D.	(Degree or title)	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 2-16-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2/19/53	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. FEB 17 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE G. Wade Granberry	ADDRESS 4202 Finney Ave
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*P. (Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

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

Melvin E. Green

Licensed Embalmer No. *4428*

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.