

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 4 - 1953

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 633

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chestfield</u>	
c. LENGTH OF STAY (in this place) <u>8 days</u>		d. STREET ADDRESS (If rural, give location) <u>Rt. 2 Box 69</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>ARTHUR</u> b. (Middle) <u>S</u> c. (Last) <u>Williams</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 20 1953</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH: <u>Unknown</u>		9. AGE (In years last birthday) <u>Abt 60</u>		10. UNDER 1 YEAR Months _____ Days _____	
11. BIRTHPLACE (City and State or Foreign Country) <u>Unknown Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>			

13a. FATHER'S NAME <u>Dowel Williams</u>		13b. MOTHER'S MAIDEN NAME <u>Lizzie Brown</u>		14. NAME OF HUSBAND OR WIFE <u>Ada Williams</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Joseph Ellis, Indianapolis, Inda.</u>	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ASCVD with decompensation</u>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Alteation of lung</u>				INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4221</u>				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?	
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22. I hereby certify that I attended the deceased from 2-13-1953 to 2-20-1953, that I last saw the deceased alive on 2-20-1953, and that death occurred at 7:20 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Belmont L. Hicks M.D.</u> (Degree or title)		23b. ADDRESS <u>6019 Brentwood, Chester 5, Mo.</u>		23c. DATE SIGNED <u>2-20-53</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-25-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Ceme.</u>		24d. LOCATION (City, town, or county) (State) <u>Chesterfield Missouri</u>	
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DATE REC'D BY LOCAL REG. <u>2-24-53</u>		REGISTRAR'S SIGNATURE <u>Hester R. Danks-M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>People's Und. Co.</u>		ADDRESS <u>3100 Franklin Av.</u>	
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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

*H. Claude Gyalon*

Licensed Embalmer No. *3489*

P. O. Address *4575 Alder*

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.