

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

15523

State File No.

4072

Registrar's No.

FILED MAY 14 1953

318

1003

BIRTH NO.

REG. DIST. NO.

PRIMARY REG. DIST. NO.

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) St. Louis		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2119
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			d. STREET ADDRESS (If rural, give location) 3047 Madison		
3. NAME OF DECEASED (Type or Print) a. (First) Willie		b. (Middle)	c. (Last) Bryant	4. DATE OF DEATH (Month) (Day) (Year) April 17 1953	
5. SEX M	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 1-7-1884	9. AGE (In years, month, days, hours, min.) 69	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St Louis MO		12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Viola Bryant (Dead)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mable Smith 3047 Madison St		
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, ashenic, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Rectum ANTECEDENT CAUSES Morbid 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. None			INTERVAL BETWEEN ONSET AND DEATH 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? 154X		
22. I hereby certify that I attended the deceased from 3-4- 19 53 , to 4-17 , 19 53 , that I last saw the deceased alive on 4-17 , 19 53 , and that death occurred at 2:45a m., from the causes and on the date stated above.					
23a. SIGNATURE Edna E Brooks			23b. ADDRESS H. D. 2601 N Whittier St	23c. DATE SIGNED 4-20-53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 4-21-53	24c. NAME OF CEMETERY OR CREMATORY Oak Dale Cemetery	24d. LOCATION (City, town, or county) (State) St Louis MO	
DATE REC'D BY LOCAL REG. APR 20 1953		REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. B. Gushow 2930 Dickson St		

(Licensed Embalmer's Statement on Reverse Side)

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 Arthur L. Heilbard

Licensed Embalmer No. 4221

P. O. Address 4524 Aldine

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.