

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

27036

State File No.

FILED JUL 31 1953

318

REG. DIST. NO.

PRIMARY REG. DIST. NO.

1003

Registrar's No.

6748

BIRTH NO.

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis

c. LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE

Missouri

b. COUNTY

c. CITY OR TOWN St. Louisd. Is Residence within limits of a city or incorporated town?
Yes No d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Homer G. Phillipse. STREET ADDRESS (If rural, give location) 2656 Delmar

3. NAME OF DECEASED (Type or Print)

a. (First)

George

b. (Middle)

Williams

c. (Last)

4. DATE OF DEATH (Month) (Day) (Year)

7-2-53

5. SEX

Male

6. COLOR OR RACE

Negro7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH

4-17-18709. AGE (In years last birthday) 83IF UNDER 1 YEAR Months 2IF UNDER 1 YEAR Days 14IF UNDER 1 YEAR Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pensioned

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) Nashville Tenn.12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME

Unknown

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

Mary Williams15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No16. SOCIAL SECURITY NO. ?17. INFORMANT'S SIGNATURE OR NAME Hospital Record

ADDRESS

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

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)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Aplasia, Rt. Kidney
Lithiasis, Rt. Kidney

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

Undt.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

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) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 443X22. I hereby certify that I attended the deceased from 7-1-, 1953, to 7-2-, 1953, that I last saw the deceased alive on 7-2-, 1953, and that death occurred at 7:05Pm., from the causes and on the date stated above.

23a. SIGNATURE

Wm. H. Linkler, M. D.

(Degree or title)

23b. ADDRESS

2601 N. Whittier St.

23c. DATE SIGNED

7-6-53

24a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24b. DATE

7-9-53

24c. NAME OF CEMETERY OR CREMATORY

Oakdale

24d. LOCATION (City, town, or county)

Lemay,Mo.

(State)

DATE REC'D BY LOCAL REG.

JUL 8 1953

REGISTRAR'S SIGNATURE

J. Carl Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE

EB House

ADDRESS

1221 N. Grand

(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.....
Signature of Student Embalmer

Signed Barrence Brown.....

Licensed Embalmer No. 4758

P. O. Address 1221 N. Main

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.