

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34329**  
**8627**

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) a. STATE <b>M.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or TOWN <b>St. Louis</b> )		c. CITY OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place) <b>Life</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>II5 N Channing Ave.</b>		e. STREET ADDRESS (If rural, give location) <b>21 II5 N. Channing Ave.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Perry</b>	b. (Middle) <b>Toney</b>	c. (Last) <b>Williams</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug, 31 1953</b>
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5. SEX <b>Male 2</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 30, 1891</b>	9. AGE (In years last birthday) <b>62</b>	IF UNDER 1 YEAR Months <b>3</b>	IF UNDER 12 HRS. Days <b>1</b> Hours <b>1</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Molder</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Century Elec. Co.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
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13a. FATHER'S NAME <b>? Williams</b>	13b. MOTHER'S MAIDEN NAME <b>? Jackson</b>	14. NAME OF HUSBAND OR WIFE <b>Edna Williams</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Edna Williams</b>	ADDRESS <b>II5 N. Channing Ave.</b>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral apoplexy</b>		<b>24 hrs</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b>		<b>1 yr</b>
DUE TO (c)		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"/>
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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) <b>334X</b>
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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?
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22. I hereby certify that I attended the deceased from **8/28, 1953**, to **8/31, 1953**, that I last saw the deceased alive on **8/31, 1953**, and that death occurred at **8 P** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Walter C. Payne MD</b> (Degree or title)	23b. ADDRESS <b>31469 Laclede</b>	23c. DATE SIGNED <b>9/2/53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Sept, 5, 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. M.</b>
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DATE REC'D BY LOCAL REG. <b>SEP 4 1953</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Wright Funeral Home</b>	ADDRESS <b>#3100 Easton Ave.</b>
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(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 *Arthur L. Billie*

Licensed Embalmer No. *423*

P. O. Address *4524*

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.