

FILED NOV 27 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40790**
Registrar's No. **10993**

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

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. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 20 2950 Cass	

3. NAME OF DECEASED (Type or Print) a. (First) Willie b. (Middle) c. (Last) Long			4. DATE OF DEATH (Month) (Day) (Year) 11 16 53		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6-29-1898	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Albert Lone		13b. MOTHER'S MAIDEN NAME Mattie ?		14. NAME OF HUSBAND OR WIFE Ebbie Long	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ebbie Long 2950^e Cass.	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malignant Hypertension with Encephalopathy Undt.		INTERVAL BETWEEN ONSET AND DEATH
	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. Hypertensive Cardiovascular Disease		

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? 441X	

22. I hereby certify that I attended the deceased from **11-12, 1953**, to **11-16, 1953**, that I last saw the deceased alive on **11-16, 1953**, and that death occurred at **11:00 Am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E. B. Williams, M.D.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 11-17-53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Nov 20/53		24c. NAME OF CEMETERY OR CREMATORY Greenwood Miss	

DATE REC'D BY LOCAL REG. NOV 19 1953		REGISTRAR'S SIGNATURE J. Earl Smith Md		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. G. Hean 4214 Dehman	
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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.....
Signature of Student Embalmer

Signed *Leroy U. Fanniate*

Licensed Embalmer No... *452*

P. O. Address... *3880 E...*

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.