

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41388

FILED NOV 27 1953

State File No. ....

318

1003

Registrar's No. 10887

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. ....	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>2810 Pine St.</u>		<u>2216</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Eliza</u>		b. (Middle) _____		c. (Last) <u>Williams</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>13</u> (Year) <u>53</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Dec. 19, 1863</u>	
9. AGE (In years last birthday) <u>90</u>		IF UNDER 1 YEAR Months <u>11</u> Days _____		IF UNDER 2 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) <u>St. Charles, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <u>Nelson Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Broadwaters</u>		14. NAME OF HUSBAND OR WIFE <u>Sam Williams</u>	
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>Katherine Webb, 2810 Dickson</u> 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, asthma, etc. It means the disease, infarct, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Undt.</u>	
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"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____ <u>794X</u>			
22. I hereby certify that I attended the deceased from <u>7-14</u> , 19 <u>53</u> , to <u>11-13</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>11-13</u> , 19 <u>53</u> , and that death occurred at <u>6:30A m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. B. Williams M.D.</u>				23b. ADDRESS <u>2601 N. Whittier</u>		23c. DATE SIGNED <u>11-13-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Nov. 18, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grave</u>		24d. LOCATION (City, town, or county) (State) <u>St. Charles, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>NOV 16 1953</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. B. Koonce - 1221 N. Grand</u>		ADDRESS _____	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 *Guyton Swan*.....

Licensed Embalmer No. *4580*.....

P. O. Address *231 N. Grant*.....

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.