

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36128  
Registrar's No. 7997

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1009</b>		Registrar's No. <b>7997</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____			
b. CITY OR TOWN <b>St Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>3026 Delmar</b>				e. STREET ADDRESS (If rural, give location) <b>27 3026 Delmar 221/10</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b>			b. (Middle) <b>Williams</b>		c. (Last) _____		
4. DATE OF DEATH (Month) (Day) (Year) <b>8-20-54</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	
8. DATE OF BIRTH <b>5-21-1922</b>		9. AGE (In years last birthday) <b>32</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Ar Kansas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Nelson Williams</b>		13b. MOTHER'S MAIDEN NAME <b>Bertha Huff</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Bertha Huff Selbourn Mo</b> 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Inter-Thoracic Hemorrhage</b> ANTECEDENT CAUSES <b>Control. Stab wound of chest (acc.) suffered when stabbed with knife in hands of one Louise Love in room of home at 3026 Delmar about 4:50 A.M. Aug 20, 1954</b> 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.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>Homicide</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Homicide</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>See above</b>		21c. (CITY, TOWN, OR TOWNSHIP) <b>St. Louis</b> (COUNTY) <b>Mo</b> (STATE) <b>Mo</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>9/20/54 - 4:50A m.</b>	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>See above</b>		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>5:00A</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>Atchek S Taylor Corcoran</b> (Degree or title) _____				23b. ADDRESS <b>305 Clark Ave</b>		23c. DATE SIGNED <b>9/20/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>		24b. DATE <b>Aug 29 54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Semmon Cem</b>		24d. LOCATION (City, town, or county) (State) <b>Wilbourn Mo</b>	
DATE REC'D BY LOCAL REG. <b>AUG 30 1954</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>ROWLAND AKER MORTUARY</b> ADDRESS _____			

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 *J. Allen Davis, Jr.*  
Licensed Embalmer No.....

P. O. Address *St. Louis*.....

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.