

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 44131

11382

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 Illinois b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN E. St. Louis		8120					
d. FULL NAME OF HOSPITAL OR INSTITUTION The Peoples Hospital				d. STREET ADDRESS (If rural, give location) 341^R Brady Avenue							
3. NAME OF DECEASED (Type or Print) a. (First) Infant b. (Middle) _____ c. (Last) Williams			4. DATE OF DEATH (Month) (Day) (Year) 9-26-54								
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____		8. DATE OF BIRTH 9-26-54					
9. AGE (In years last birthday)		10. MONTHS		11. DAYS		12. IF UNDER 14 YEARS Hours Min. 7 20					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) St. Louis, Missouri					
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13a. FATHER'S NAME _____		13b. MOTHER'S MAIDEN NAME Gussie Williams		14. NAME OF HUSBAND OR WIFE _____				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Gussie Williams				ADDRESS E. St. Louis, 11 341 R. Brady Ave.			
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) Pneumonia ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Subacute Peritonitis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? 7615							
22. I hereby certify that I attended the deceased from 9/26/54 , to 9/26 , 19 54 , that I last saw the deceased alive on 9:40 A.M. , 19 54 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above.											
23a. SIGNATURE Edgar F. Worden M.D.				23b. ADDRESS 930 W. 2ND ST				23c. DATE SIGNED 9/30/54			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE DEC 3 1 1954		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.					
DATE REC'D BY LOCAL REG. DEC 14 1954		REGISTRAR'S SIGNATURE J. Carl Smith MO				25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service					
				ADDRESS St. Louis 10, Mo.							

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.