

FILED FEB 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3252**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **0780**

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| 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) OR TOWN St. Louis | | c. LENGTH OF STAY (in this place) | c. CITY OR TOWN St. Louis |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| | | STREET ADDRESS (If rural, give location) 415 S. Garrison | |

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|--|-------------|---------------------------|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) Nancy | b. (Middle) | c. (Last) Williams | 4. DATE OF DEATH (Month) (Day) (Year) 1 25 55 |
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| 5. SEX F 3 | 6. COLOR OR RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH June 1, 1876 | 9. AGE (in years last birthday) 78 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours | Min. |
|-------------------|-------------------------------|---|--------------------------------------|---|------------------------|-----------------------|-------|------|

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| 10a. USUAL OCCUPATION (If the kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) Macon, Mississippi | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME Thornton Williams | 13b. MOTHER'S MAIDEN NAME Estes | 14. NAME OF HUSBAND OR WIFE James Williams |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME James Williams | ADDRESS 415 S. Garrison |
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| 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, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH Undt. |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uterus - Adenocarcinoma | | |
| | 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. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) |
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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? 174X |
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22. I hereby certify that I attended the deceased from **7-14**, 19**54**, to **1-25**, 19**55**, that I last saw the deceased alive on **1-25**, 19**55**, and that death occurred at **10:05A** m., from the causes and on the date stated above.

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| 23a. SIGNATURE William L. Smiley | (Degree or title) M.D. | 23b. ADDRESS 2601 N. Whittier | 23c. DATE SIGNED 1-26-55 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE Jan 31, 1955 | 24c. NAME OF CEMETERY OR CREMATORY Washington Park | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo |
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| DATE REC'D BY LOCAL REG. JAN 27 1955 | REGISTRAR'S SIGNATURE J. Earl Smith M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE E. B. Kooze | ADDRESS 122 N. Grand |
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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 *Gayton Swann*.....

Licensed Embalmer No. *458*

P. O. Address *177, N. 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.