

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23640****5342**

FILED AUG 2 - 1955

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY					
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis		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 Homer G. Phillips Hospital				STREET ADDRESS (If rural, give location) 21 2206 Carr 2219					
3. NAME OF DECEASED (Type or Print) a. (First) Lorena			b. (Middle)		c. (Last) Davidson		4. DATE OF DEATH (Month) 6 (Day) 17 (Year) 55		
5. SEX F		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH July 23 1883		9. AGE (In years last birthday) 71 10. Months 10	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country)			12. CITIZEN OF WHAT COUNTRY?	
Housewife			None		Choctaw, Alabama				
13a. FATHER'S NAME Zack Williams			13b. MOTHER'S MAIDEN NAME Joseph			14. NAME OF HUSBAND OR WIFE Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Ethel Lacy ADDRESS 2343 Cole				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular Thrombosis				DUE TO (b) Hypertensive Cardiovascular Disease				Undt.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Uremia;									
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? 443x				
22. I hereby certify that I attended the deceased from 6-10 , 19 55 , to 6-17 , 19 55 , that I last saw the deceased alive on 6-17 , 19 55 , and that death occurred at 6:45 a.m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Edw. B. Williams, M.D.				23b. ADDRESS 2601 N. Whittier			23c. DATE SIGNED 6-18-55		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE June 23, 1955		24c. NAME OF CEMETERY OR CREMATORY Oakdale		24d. LOCATION (City, town, or county) (State) Lemay Missouri			
DATE REC'D BY LOCAL REG. JUN 20 1955		REGISTRAR'S SIGNATURE J. Carl Smith			25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS M. B. Kooze 1221 N Grand				

(Licensed Embalmer's Statement on Reverse Side)

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..... *Lufta Swan*

Licensed Embalmer No. *458*

P. O. Address *1221 1/2*

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.