

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24576**
Registrar's No. **6349**

FILED AUG 15 1955

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 town or township) St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place)		STREET ADDRESS (If rural, give location) 25 1314 Biddle Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital			

3. NAME OF DECEASED (Type or Print) Savannah Williams	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 7 21 55
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5. SEX ♀	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 10-15-79	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Med	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Miss	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Pitman	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE
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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.	17. INFORMANT'S SIGNATURE OR NAME Connie Jeffers	ADDRESS 2935 Jackson
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH Undt.
	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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **7-8-**, 19**55**, to **7-21-**, 19**55**, that I last saw the deceased alive on **7-21-**, 19**55**, and that death occurred at **3:45a.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 Street	23c. DATE SIGNED 7-21-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE July 26/55	24c. NAME OF CEMETERY OR CREMATORY Oak Dale Cem	24d. LOCATION (City, town, or county) (State) St Louis MO
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DATE REC'D BY LOCAL REG. JUL 23 1955	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE F. H. Green	ADDRESS 4214 Delmar
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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.....

Licensed Embalmer No. 296

P. O. Address 4214 Delm

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.