

health, Welfare Public service  
 300 0-56  
 symptoms with or without  
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JAN 15 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

44099  
 STATE FILE NUMBER  
 1003  
 11859  
 Registrar's No.

Registration District No. 318 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>			Length of stay in lb		d. STREET ADDRESS <b>4130 Delmar</b>		(If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Arlena</b> Middle <b>Ray</b> Last <b>Williams</b>			4. DATE OF DEATH Month <b>12</b> Day <b>23</b> Year <b>56</b>						
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-26-1900</b>		9. AGE (In years last birthday) <b>56</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Homer Phillips</b>		11. BIRTHPLACE (City and state or country) <b>Marvel Ark.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>William Fitzgerl</b>					14. MOTHER'S MAIDEN NAME <b>Frankie Fitzgerl</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No No</b>			16. SOCIAL SECURITY NO. <b>499-348443</b>		17. INFORMANT <b>Ada Dortch</b> Address <b>4130 Delmar Ave.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b>								INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular Disease</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			<b>443x</b>						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>12-11-56</b> to <b>12-23-56</b> and last saw her <sup>her</sup> <del>him</del> alive on <b>12-23-56</b> Death occurred at <b>2:55 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Hugh Waters</b> (Degree or title) <b>M.D.</b>					22b. ADDRESS <b>2601 Whittier Street</b>			22c. DATE SIGNED	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <b>12-27-56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		23d. LOCATION (City, town, or county) <b>St. Louis, County</b>		(State) <b>Mo</b>		
24. FUNERAL DIRECTOR <b>J. McClendon</b> ADDRESS <b>4535 Washington Blvd</b>				25. DATE RECD. BY LOCAL REG. <b>DEC 26 1956</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>			

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 *John K. Cunningham* .....

Licensed Embalmer No. *45*

P. O. Address *2705 9th*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.