Health, Welfare Public Service

FILED FEB 4 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 44909

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 743

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis MO — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 01 524 S Owing — Length of stay in 1b
d. STREET ADDRESS (If outside, give location) 22 524 S. Owing — Reside on Farm Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO — b. COUNTY
c. CITY OR TOWN St Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 9 22 524 S. Owing — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Myrtle Middle Last Williams

4. DATE OF DEATH Month 12 Day 26 Year 56

5. SEX Fem
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐ Unknown
8. DATE OF BIRTH 1909
9. AGE (In years last birthday) 47
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk
10b. KIND OF BUSINESS OR INDUSTRY Unk
11. BIRTHPLACE (City and state or country) Unk 9
12. CITIZEN OF WHAT COUNTRY? Unk

13. FATHER'S NAME Unk
14. MOTHER'S MAIDEN NAME Unk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unk (If yes, give war or dates of service) Unk
16. SOCIAL SECURITY NO. Unk
17. INFORMANT Address R. Taylor of Bo Clark

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Alcoholism
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 322.0
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 _____, to _____ and last saw her/him alive on _____
Death occurred at 7:50 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M. Quinn Deputy Pres 3
22b. ADDRESS 1300 Clark
22c. DATE SIGNED 1/3/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Rowland-Aker Mortuary Service
23b. DATE 1-31-57
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board
23d. LOCATION (City, town, or county) St. Louis, Mo. (State)

24. FUNERAL DIRECTOR ADDRESS 4104 Manchester Ave. St. Louis 10, Mo.
25. DATE RECD. BY LOCAL REG. JAN 24 '57
26. REGISTRAR'S SIGNATURE J. Earl Smith MD MDB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student..... Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address .....

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.