

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30182

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 7089

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7089			
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) St. Louis		c. LENGTH OF STAY (in this place) 3 Weeks		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 16 Missouri Baptist Hospital				e. STREET ADDRESS (If rural, give location) 2237 2009 Congress St.					
3. NAME OF DECEASED (Type or Print) Silas			a. (First)		b. (Middle) M.		c. (Last) Williams		
4. DATE OF DEATH July 28, 1957		4. DATE (Month) (Day) (Year)		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH September 14, 1887		9. AGE (In years last birthday) 69		10. DATE OF BIRTH		11. BIRTHPLACE (City and State or Foreign Country) Morse Mill, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Forester		10b. KIND OF BUSINESS OR INDUSTRY City of St. Louis		11. BIRTHPLACE (City and State or Foreign Country)		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Alfred Williams			13b. MOTHER'S MAIDEN NAME Mary Wideman			14. NAME OF HUSBAND OR WIFE Christine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 492-12-8104		17. INFORMANT'S SIGNATURE OR NAME Mrs. Carrie Horn		ADDRESS 2009 Congress St.			
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA of LARYNX & PHARYNX				INTERVAL BETWEEN ONSET AND DEATH	
				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		19c. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 2 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from July 27, 1957, to July 28, 1957, that I last saw the deceased alive on July 27, 1957, and that death occurred at 7:40A m., from the causes and on the date stated above.									
23a. SIGNATURE Vernon M. Ferguson M.D.				23b. ADDRESS ST. LOUIS 8, MO		23c. DATE SIGNED 7/29/57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7/31/57		24c. NAME OF CEMETERY OR CREMATORY New Local Cemetery		24d. LOCATION (City, town, or county) (State) Cedar Hill, Missouri			
DATE REC'D BY LOCAL REG. JUL 30 57		REGISTRAR'S SIGNATURE J. C. Smith		25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons		ADDRESS 2630 Gravois Ave.			

m & z (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 *Robert T. Gibson*.....

Licensed Embalmer No. 4144.....

P. O. Address 2630 Gravois. A.....

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.