

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-012497

STATE FILE NUMBER

FILED APR 9 1958

Registration District No. **318** Primary Registration District No. **1003**

Registrar's No. **3226**

health, Welfare Public Service  
 3300 1-56  
 All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

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, Mo.</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>Womer Phillips H.</b>			Length of stay in 1b		STREET ADDRESS (If outside, give location) <b>5217 Raymond</b>
3. NAME OF DECEASED (Type or print) <b>Horace Williams</b>			4. DATE OF DEATH <b>March 15, 1958</b>	Month Day Year	
5. SEX <b>Male 2</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED 2</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1876</b>	9. AGE (In years last birthday) <b>82</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>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Mocon, Mississippi /</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Horace Williams, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Mary J. Tillman 5217 Raymond</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>Cerebral Apoplexy</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(n)					19. WAS AUTOPSY PERFORMED? <b>334x</b> YES <input type="checkbox"/> NO <input checked="" 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.) <b>2</b>		
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year					
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 _____ to _____ and last saw her/him alive on _____ Death occurred at <b>355A</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree of title) <b>James M. Kelly Deputy Coroner</b>			22b. ADDRESS <b>3 1300 Clark</b>		22c. DATE SIGNED <b>3-17-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>	23b. DATE <b>3/24/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
24. FUNERAL DIRECTOR <b>G. Wade Granberry 4202 Finney Ave.</b>			25. DATE RECD. BY LOCAL REG. <b>MAR 19 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> <i>m. j. B.</i>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MAY 19 1958

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- 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 *Edward A. Flynn*.....

Licensed Embalmer No. 4444

P. O. Address 4202 Finney

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