

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015965

Health,  
Welfare  
Public  
Service

STATE FILE NUMBER  
Registration No. **21007**

FILED MAY 11 1959

Registration District No. \_\_\_\_\_ Primary Registration District 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, Missouri.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Enroute City Hospital</b>		Length of stay in lb.	d. STREET ADDRESS (If outside, give location) <b>2937 Nebraska Avenue,</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Melton Williams</b>			4. DATE OF DEATH Month Day Year <b>April 22, 1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 20, 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Confectionery Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Confectionery</b>	9. AGE (In years last birthday) <b>63</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS
11. BIRTHPLACE (City and state or country) <b>Indian Territory, Oklahoma</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William Thomas Williams</b>		13b. MOTHER'S MAIDEN NAME <b>Julia Watkins</b>	14. NAME OF HUSBAND OR WIFE <b>Mabel Williams</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No Nil</b>		16. SOCIAL SECURITY NO. <b>499-12-0501</b>	17. INFORMANT Address <b>Mabel Williams, 2937 Nebraska Avenue.,</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>Coronary Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic Vascular disease</b> DUE TO (c) <b>420.1</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 Yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Had coronary thrombosis 6 years ago.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.			
20d. INJURY OCCURRED WHILE AT <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>1955</b> to <b>Apr. 22 1959</b> and last saw <sup>her</sup> him alive on <b>4/18/59</b> Death occurred at <b>7:00 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Dr. Deabaugh M.D.</b>		22b. ADDRESS <b>Webster Groves Mo</b>	22c. DATE SIGNED <b>4/23/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>4-23-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Carter Graveyard</b>	23d. LOCATION (City, town, or county) (State) <b>Salem, Missouri.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.,</b>		25. DATE RECD. BY LOCAL REG. <b>APR 23 '59</b>	26. REGISTRAR'S SIGNATURE <b>Roal Smith, M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

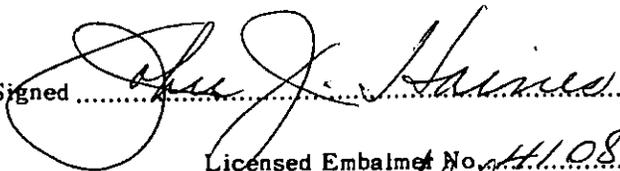
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

**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. H108 .....  
P. O. Address Harris, Mo .....

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.