

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019774

STATE FILE NUMBER

2 5297

FILED JUN 15 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registration No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Lovejoy</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>St. Mary's Infirmary</b>		Length of stay in 1b <b>4 days</b>	d. STREET ADDRESS (If outside, give location) <b>308 Washington</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ALZADIA</b> Middle _____ Last <b>WILLIAMS</b>			4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1959</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>Feb 9, 1910</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Resteraunt</b>	9. AGE (In years last birthday) <b>49</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>Pickings, Miss.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Gary Thornton</b>		13b. MOTHER'S MAIDEN NAME <b>Lula McCoy</b>	
14. NAME OF HUSBAND OR WIFE		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>Unknown</b>		17. INFORMANT Address <b>John Williams-308 Washington, Lovejoy, Ill.</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 occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <input checked="" type="checkbox"/> DUE TO (c) <input checked="" type="checkbox"/> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.1</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
19. WAS AUTOPSY PERFORMED? 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>/</b>		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.) <b>5-25-59</b>	
20f. CITY, TOWN, OR LOCATION <b>Lovejoy, Ill.</b>		COUNTY _____ STATE _____	
21. I attended the deceased from <b>May 25-1959</b> to <b>May 31-1959</b> and last saw her alive on <b>May 29-1959</b> Death occurred at <b>May 31 5:15A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Earle Williams</b> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>301 Maple St. Lovejoy, Ill.</b>	
22c. DATE SIGNED <b>June 1959</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>June 2, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town, or county) (State) <b>East St. Louis, Ill.</b>		24. FUNERAL DIRECTOR <b>Marshall Funeral Home - St. Louis, Ill</b>	
25. DATE RECD. BY LOCAL REG. <b>JUN 2 '59</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <i>mjb</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Thomas M. Hobson* .....

Licensed Embalmer No. 4479 .....

P. O. Address East St. Louis, Ill. ....

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.