

**FEDERAL BUREAU OF INVESTIGATION
DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS AUG 4 1959

59-027356

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. **6879**

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, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
Length of stay in 1b 19 Yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HOMER G. PHILLIPS HOSPITAL		d. STREET ADDRESS (If outside, give location) 2913, DICKSON STREET	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First ARNETTER Middle WILLIAMS Last _____			Month 07 - Day 20 - Year 1959			
5. SEX FEMALE	6. COLOR OR RACE COL.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/29/1912	9. AGE (last birthday) 47	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTICTS	11. BIRTHPLACE (City and state or country) NUELTON LOUISEANA		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE JOHNIE WILLIAMS		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Janie Williams	Address 2813, DICKSON ST.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Massive uterine hemorrhage		2 hour 20 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma of uterus	
	DUE TO (c) 174x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.) none
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year none	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none	20f. CITY, TOWN, OR LOCATION COUNTY STATE none

21. I attended the deceased from **July 1, 1959** to **July 20, 1959** and last saw her **alive** on **July 19, 1959**
Death occurred at **6 20 P** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Frederic D. Alexander M.D.	22b. ADDRESS 826 N Channing St. Home	22c. DATE SIGNED 7-21-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7/27/59	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK CEMETERY
23d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI		

25. DATE RECD. BY LOCAL REG. JUL 24 '59	26. REGISTRAR'S SIGNATURE Roald Smith, M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

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. 4441

P. O. Address 2812, Fho

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.