

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027357

FILED VS AUG 11 1959

2 7048

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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 915 N. GRAND, ST. LOUIS, MO.	Length of stay in 1b 22 days	c. CITY OR TOWN ST. LOUIS	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 318 S. JEFFERSON
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First CALVIN Middle Last WILLIAMS	4. DATE OF DEATH Month JULY Day 28 Year 1959
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5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/8/30	9. AGE (last birthday) 29	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) MACHINE OPERATOR	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) HOUSTON, TEXAS	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME MOSE WILLIAMS	13b. MOTHER'S MAIDEN NAME ELMIRA THOMAS	14. NAME OF HUSBAND OR WIFE - - - - -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES KOREAN	16. SOCIAL SECURITY NO. 500-26-6708	17. INFORMANT VA HOSP. RECORDS, ST. LOUIS, MO.	Address
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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 9 MONTHS
IMMEDIATE CAUSE (a) MALIGNANT HYPERTENSION		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) SUBACUTE GLOMERULONEPHRITIS	-
	DUE TO (c) 445X -	-

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 type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> NONE	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour VA s.m. p.m.	Month, Day, Year
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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 VA	COUNTY	STATE
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21. I attended the deceased from 7/6/59 to 7/28/59 and last saw him alive on 7/28/59 Death occurred at 3:55 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>John H. Winter</i> M.D. WINTER	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 7-29-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-3/59	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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24. FUNERAL DIRECTOR G. Wade Granberry	ADDRESS 4202 Finney Ave.	25. DATE RECD. BY LOCAL REG. JUL 30 59	26. REGISTRAR'S SIGNATURE <i>John Smith, M.D.</i>
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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
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. (Failure to conform 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.