

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044781

NOV 17 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3191

1. PLACE OF DEATH a. COUNTY <u>County</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Missouri</u>		Length of stay in 1b <u>199 days</u>	c. CITY OR TOWN <u>St. Louis, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3711 Hickory</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>--</u> Last <u>Williams</u>			4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-30-13</u>	9. AGE (last birthday) <u>47</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u> Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nil</u>	11. BIRTHPLACE (City and state or country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Ernest Williams</u>		13b. MOTHER'S MAIDEN NAME <u>Lula Washington</u>		14. NAME OF HUSBAND OR WIFE <u>Edrean Williams</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>494-28-0923</u>	17. INFORMANT Address <u>Records at Koch Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cystic Bullous emphysema</u>					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Chronic Bronchitis</u>				
		DUE TO (c) <u>502.0</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchiectasis (bilateral) Chronic recurrent bronchitis Left ventricular hypertrophy with cardiac decompensation.</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N- <input type="checkbox"/> Unknown		
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"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
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 <u>4-16-60</u> to <u>11-2-60</u> and last saw her/him alive on <u>11-2-60</u> Death occurred at <u>9:05</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Harold G. Russell, MD</u> (Designs or title)			22b. ADDRESS <u>Robert Koch Hospital</u>		22c. DATE SIGNED <u>11-2-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>11-5-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>		
24. FUNERAL DIRECTOR <u>Ellis Funeral Home</u>		ADDRESS <u>2820 Stoddard Street</u>	25. DATE RECD. BY LOCAL REG. <u>11-4-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

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 Fulton E. Culbert

Licensed Embalmer No. 4198

P. O. Address Straw...

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.