SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3246 STATE FILE NUMBER -61-011111

FILED APR 14 1961

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DOCUMENT

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 — Length of stay in 1b

c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 3893a Delmar — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First William Middle Last King

4. DATE OF DEATH Month 4 Day 2 Year 61

5. SEX Male

6. COLOR OR RACE Negro

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 11-26-1894

9. AGE (last birthday) 66 — 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) labor

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (City and state or country) Louisiana

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Levi King

13b. MOTHER'S MAIDEN NAME Littie Williams

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs.Grant Address Detroit,Michigan

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis with Right Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH Undet.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 332x

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 3-30-61, to 4-2-61 and last saw him alive on 4-2-61

Death occurred at 2:00 p.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Sydney A. Mason, M. D.

22b. ADDRESS 2601 N. Whittier St.

22c. DATE SIGNED 4-3-61

23a. BURIAL, CREMATION, REMOVAL (Specify) removal

23b. DATE 4-10-61

23c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery

23d. LOCATION (City, town, or county) (State) St.Louis Co.,Mo.

24. FUNERAL DIRECTOR Dunn Funeral Home ADDRESS 3847 Page Blvd.

25. DATE RECD. BY LOCAL REG. APR 6 1961

26. REGISTRAR'S SIGNATURE Carl Smith M.D.

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

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.