

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009631

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 19 1963

318

Primary Registration District No.

1003

Registrar's No.

1574

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT
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77	SHOULD READ	BY AFFIDAVIT OF	

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	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 1810 N. Grand	
3. NAME OF DECEASED (Type or print) Sam Williams		4. DATE OF DEATH Month 2 Day 11 Year 63	
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1888
9. AGE (last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	
11. BIRTHPLACE (City and state or country) Augusta, Georgia		12. CITIZEN OF WHAT COUNTRY U. S.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Virginia Williams, dec		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.		17. INFORMANT Address Geo. H. Wise, grandson 4041 Finney Ave - St. Louis, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH Undet.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 420.1		DUE TO (c)	
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	
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.)	
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 1-26-63 to 2-11-63 and last saw her him alive on 2-11-63		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 B. Prophete MD		22b. ADDRESS 2601 N. Whittier	
22c. DATE SIGNED 2-11-63		23a. BURIAL, CREMATION, REMOVAL (Specify) Removed	
23b. DATE Feb 18, 1963		23c. NAME OF CEMETERY OR CREMATORY Father Dickson	
23d. LOCATION (City, town, or county) St Louis		23e. (State) MO	
24. FUNERAL DIRECTOR F. J. Green 424 Delmar		25. DATE RECD. BY LOCAL REG. FEB 13 1963	
26. REGISTRAR'S SIGNATURE Paul Smith, M.D.			

USE BLACK INK OR TYPEWRITER RIBBON

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 F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

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.