

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-018377

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4259** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

VS 300
 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

1. FILED APR 23 1963		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY St. Louis Mo		a. STATE MO	b. COUNTY St. Louis
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo		c. CITY OR TOWN St. Louis	
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hosp		d. STREET ADDRESS 2143 O'Fallon	Inside Limits Reside on Farm
3. NAME OF DECEASED (Type or print) First Allen Middle William Last Williams		4. DATE OF DEATH Month 4 Day 13 Year 1963	
5. SEX M	6. COLOR OR RACE Col.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-28-76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ARKANSAS
13a. FATHER'S NAME Sam Williams		13b. MOTHER'S MAIDEN NAME Charlotte	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MILTON LARKINS		Address 2143 O'Fallon St. Apt. 401	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION DUE TO (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) 4201 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Decubiti - Chronic Pneumonitis			INTERVAL BETWEEN ONSET AND DEATH 48 Hours 20 YEARS
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"/>	
20c. TIME OF INJURY Hour 5:55 Month, Day, Year 12-20-49		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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 12-20-49 to 4-13-63 and last saw her/him alive on 4-13-63 Death occurred at 5:55 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John Keeney M.D. (Degree or title)		22b. ADDRESS 5800 Arsenal Ave	
22c. DATE SIGNED 4-12-63		23. NAME OF CEMETERY OR CREMATORY FATHER DICKSON CEM. ST. LOUIS COUNTY MO.	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 4-19-63	
24. FUNERAL DIRECTOR LUKE JONES ADDRESS 1343 N. GARRISON AVE.		25. DATE RECD. BY LOCAL REG. APR 17 1963	
26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

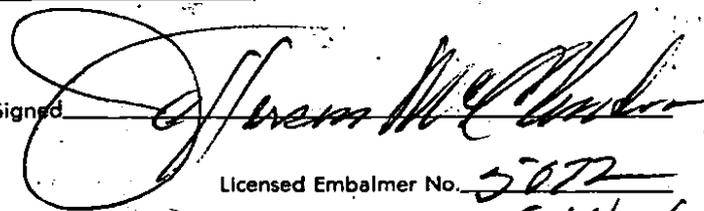
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STATEMENT BY LICENSED EMBALMER

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. 5072

P. O. Address 4535 Washington

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.

04-4

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