

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

17373  
Do not use this space.

781  
1008

4907

1. PLACE OF DEATH

(a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No.....  
 (c) City St. Louis (d) Street No. City Hospital No. 1 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Jack Williams  
 (a) Residence, No. 3225 Montgomery St (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 14, 1861  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
77 8 17

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. nil  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

13. NAME Henry Williams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

15. MAIDEN NAME Synia ?

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

17. INFORMANT (ADDRESS) Hosp. Info R. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington DATE 5/10/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Richter 3100

20. FILED MAY 31 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/1/39 19  
 22. I HEREBY CERTIFY, That I attended deceased from 4/21/39 19 to 5/1/39 19  
 I last saw him on 5/1/39 19. Death is said to have occurred on the date stated above, at 9.40 a.m.  
 The principal cause of death and related causes of importance were as follows:

Carcinoma of Prostate Date of onset

Other contributory causes of importance

Name of operation Date of  
 What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Date of injury, 19  
 Where did injury occur? (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury  
 Nature of injury

Was disease or injury in any way related to occupation of deceased?  
 If so specify

(Signed) William Sapsin, M.D.  
 (Address) City Hospital No. 1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**