

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

2966

Registration District No.

7911

Primary Registration District No.

1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer Phelley's
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME MALINDA WILLIAMS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years abt 50 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country) TENN

10. Usual occupation Homemaker

11. Industry or business _____

MOTHER FATHER

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. (a) Informant's own signature John Williams

(b) Address 2125 Papen

17. (a) (Burial, cremation, or removal) buried (b) Date thereof 3-2-40
(Month) (Day) (Year)

(c) Place of burial or cremation _____

18. (a) Signature of funeral director [Signature]

(b) Address 3800 Ridge

19. (a) Date received local registrar 2-29-1940 (b) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis 22
(If outside city or town limits, write "RURAL")
(d) Street No. 2125 Papen
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 29
year 1940 hour _____ minute 10 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic Myocarditis

Due to _____

Due to Chronic Hypertension

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 131
Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____
(b) Means of injury _____

23. Signature [Signature] (At. De or other) _____
Address Deputy Coroner

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.