

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.

REGISTRATION DISTRICT NO. **791**

PRIMARY REGISTRATION DISTRICT NO. **1003**

STATE FILE NO. _____

REGISTRAR'S NO. **3883**

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town **St. Louis, Mo.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **City Infirmary**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7yr. 4mo. 25days**
58 years (Specify whether years, months or days)

8. (a) PRINT FULL NAME **House Williams 452**
 8. (b) If veteran, name war **Unknown**
 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **Widowed**

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

7. Birth date of deceased **Unknown Unknown 1862**
 (Month) (Day) (Year)

8. AGE: Years **78** Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace **Unknown Tenn. 1**
 (City, town, or county) (State or foreign country)

10. Usual occupation **None 1**

11. Industry or business _____

12. Name **Jim Williams**

13. Birthplace **Unknown Va. 1**
 (City, town, or county) (State or foreign country)

14. Maiden name **Florida Unknown**
 (City, town, or county) (State or foreign country)

15. Birthplace **Unknown Tenn.**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **J. S. Sullivan**

(b) Address **5800 Arsenal St.**

17. (a) (Burial, cremation, or removal) **1** (b) Date thereof **4/30/40**
 (Month) (Day) (Year)

(c) Place: burial or cremation **1**

18. (a) Signature of funeral director **W. Richter**

(b) **APR 30 1940**

19. (a) (Date received local registrar) (b) **J. J. [Signature]**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **St. Louis 13**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **5800 Arsenal**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **4**
 year **1940** hour **11:15** minute **P. M.**

21. I hereby certify that I attended the deceased from **Mar. 28, 1940** to **April 4, 1940**
 that I last saw him alive on **April 4, 1940**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemic Heart Disease**
Intermittent
 Due to _____

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

Major findings: Of operations **None.**
 Of autopsy **None.**
 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) _____
 (e) Means of injury _____

23. Signature **James P. Murphy** (M. D. or other) _____
 Address **5600 Arsenal St.** Date signed **4-5-40**

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.