

Registration District No. **784**

Primary Registration District No. **101**

Registrar's No. **2212**

1. PLACE OF DEATH:

(a) County **St. Louis Co. Hosp.**  
 (b) City or town **St. Louis Co. Hosp.**  
(If outside city or town, give "RURAL" and name of township)  
 (c) Name of hospital or institution **St. Louis Co. Hosp.**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **22 days**  
(Specify whether)  
 In this community **16 years**  
years, months or days

8. (a) PRINT FULL NAME **MARY WILLIAMS**

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

4. Sex **F** 5. Color or race **M.** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **July 22 - 1853**  
(Month) (Day) (Year)

8. AGE: Years **87** Months **4** Days **1** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **9**

12. Name **Unknown**

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant **Oscar Williams**

(b) Address **2206 N. Water**

17. (a) **Burial** (b) Date thereof **11/25/40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Levee Ry.**

18. (a) Signature of funeral director **William**

(b) Address **2849 N. Euclid**

19. (a) **NOV 23 1940** (b) **W. H. Meigs**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Louis**  
 (c) City or town **Yunta St. Louis Co. Mo**  
(If outside city or town, give "RURAL")  
 (d) Street No. **2206 N. Water**  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **23**  
 year **1940** hour **12** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **11-1-40**  
 19\_\_\_\_ to **11-23-40** 19\_\_\_\_

that I last saw **her** alive on **11-23-40** 19\_\_\_\_  
 and that death occurred on the date and hour stated above.

Immediate cause of death:  
**Uremia**  
**Myocardial Insufficiency**  
**Nephrosclerosis**  
**Embolized Arteriosclerosis**

Duration  
**3 days**  
**2 mo.**  
**?**  
**?**

Other conditions: **Enterococcal**  
(Include pregnancy within 3 months of death)  
**Fracture R. Femur**

**22 days**  
**in hospital**  
 PHYSICIAN

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy **1/26/40**

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) **Accident**

(b) Date of occurrence **Oct. 31 - 1940**

(c) Where did injury occur? **2206 N. Water, Oakland, Mo.**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**Home**

While at work? **no** (Specify type of place)  
 (e) Means of injury **fell**

28. Signature **James Boyd** (M.D. or other)  
 Address **St. Louis Co. Hosp.** Date **11/24/40**

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

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Robert Mayfield*  
3077

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

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