

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **5305**

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:  
**St Mary's Infirmary**  
(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 **Will Washington**

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

4. Sex **Male** 5. Color or race **Colored** 6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **April 19, 1983**  
(Month) (Day) (Year)

8. AGE: Years **56** Months **5** Days **2** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **Labourer**

11. Industry or business \_\_\_\_\_

12. Name **Chas Washington**

13. Birthplace **Ala**  
(City, town, or county) (State or foreign country)

14. Maiden name **Lizzie M. Smith**

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

16. (a) Informant **Chas Washington**

(b) Address **1423 a Papin**

17. (a) \_\_\_\_\_ (b) Date thereof **6-29-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Wright's Funeral Home**

(b) Address **3100 Easton Ave**

19. (a) **JUN 27 1941** (b) **J. F. Brebeck**  
(Date of record filed) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **1100**  
(c) City or town **St Louis** **1822**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1423 Papin** **9**  
(If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **22**  
year **1941** hour **4** minute **10 P.M.**

21. I hereby certify that I attended the deceased from **6-15-41**  
to **6-22-1941**  
that I last saw him alive on **6-22-1941**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Heart Disease**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature **Chas L. Gaven** M. D. or other \_\_\_\_\_  
Address **1536 Papin St** Date signed **6-23-41**

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

06  
17  
9

**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.....  
William C. McDowell....., Registered Apprentice No.....  
working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2114

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, fact should be so stated above.**