

No. 2  
-1.4-41  
-17-39  
X26390

DEPARTMENT OF THE COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **42974**  
Registrar's No. **2588**

DEC 31 1941

Registration District No. *54*

Primary Registration District No. *200*

1. PLACE OF DEATH:

(a) County *St Louis*  
(b) City or town *Koch*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: *Robert Koch Hospital*  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution *255 days*  
(Specify whether  
In this community *12 years*  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *St Louis*  
(c) City or town *St Louis*  
(If outside city or town limits, write "RURAL.")  
(d) Street No. *1951* *St Louis Ave*  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME *WILLIAM O. GUILLIAMS*

3. (b) If veteran, name war *No.* 3. (c) Social Security No. *490-03-3579*

4. Sex *male* 5. Color or race *white* 6. (a) Single, widowed, married, divorced *married*  
6. (b) Name of husband or wife *Veda Williams (nee KNOWELS)* 6. (c) Age of husband or wife if alive *30* years *1912*  
7. Birth date of deceased *July 30* (Month) (Day) (Year)

8. AGE: Years *29* Months *4* Days *19* If less than one day hr. min.

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

10. Usual occupation *clerk*

11. Industry or business

MOTHER FATHER { 12. Name *Omar Williams*  
13. Birthplace *Piedmont Mo* (City, town, or county) (State or foreign country)  
14. Maiden name *Ora Cox*  
15. Birthplace *Redford Mo* (City, town, or county) (State or foreign country)

16. (a) Informant *Hospital Record*  
(b) Address *Robert Koch Hosp, Koch Mo*  
17. (a) *Funeral* (b) Date thereof *12-22-41*  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation *Friedens Cem.*

18. (a) Signature of funeral director *H. Leidner Und. Co.*  
(b) Address *2323 St. Louis Ave.*

19. (a) *DEC 20 1941* (b) *E. J. McFarland*  
(Date received local registrar) (Registrar's signature)

*707* (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* day *19* year *1941* hour *3* minute *45 A* M.

21. I hereby certify that I attended the deceased from *April 8* 19*41* to *Dec 19* 19*41*;  
that I last saw him alive on *Dec 19* 19*41*;  
and that death occurred on the date and hour stated above.

Immediate cause of death *Pulmonary Tuberculosis* Duration *2 yrs +*

Due to  
Due to

Other conditions *Intestinal Tuberculosis*  
(Include pregnancy within 3 months of death)

Major findings: *Tuberculosis of larynx*

Of operations  
Of autopsy *13/41*

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 *Frank Cohen* (M. D. or other) *MD*  
Address *Robert Koch Hospital* Date signed *Dec 19/41*

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

*me*

**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 Homer L. Ponder  
Licensed Embalmer No. 3367  
P. O. Address 2223 St. Louis Ave

**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.**