

S. No. 2  
M-9-4-41  
v. 5-17-39  
I X29484

16810

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....  
Registrar's No. **4549**

FILED JUN 2 1942  
791  
Registration District No. ....

Primary Registration District No. **1003**

00  
17  
9  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County St. Louis, Mo.  
(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:  
Homer Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days  
In this community 41 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: **000**  
(a) State Missouri (b) County 17  
(c) City or town St. Louis, 9 21  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1011 N. 23rd St.  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Albert Williams  
(b) If veteran, name war None  
(c) Social Security No. 497-03-5395

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 20,  
year 1942 hour 4 minute 05 P. M.  
21. I hereby certify that I attended the deceased from May 15,  
19 42 to May 20, 19 42  
that I last saw him alive on May 20, 19 42  
and that death occurred on the date and hour stated above.

4. Sex Male 2 5. Color or race Col.  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Laura 6. (c) Age of husband or wife if alive 41 years  
7. Birth date of deceased. Dec. 28, 1887  
(Month) (Day) (Year)

Immediate cause of death.....  
Lobar Pneumonia **108** 1 week

8. AGE: Years Months Days If less than one day  
54 4 22 br. min.

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

9. Birthplace Unknown Mis s. /  
(City, town, or county) (State or foreign country)

10. Usual occupation Labor

11. Industry or business W. P. A.

MOTHER FATHER { 12. Name Unknown  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Laura Williams  
(b) Address 1011 N. 23th St.

17. (a) Burial (b) Date thereof May 26, 42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park

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.....

18. (a) Signature of funeral director Dement & Son  
(b) Address 2620-31 Cole St.

19. (a) WJY 26 1017 (b) J. J. Bradock  
(Date received local registrar) (Registrar's signature)

23. Signature J. J. Bradock (M. D. or other) 0  
Address 2601 Whittier Date signed 5/21/42

844 (Licensed Embalmer's Statement on Reverse Side)

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.....  
*myself*....., Registered Apprentice No.....  
working under my personal supervision.

Signed: *William Claude Gordon*  
Licensed Embalmer No. *3459*  
P. O. Address: *2649 Welmar*

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.