

X35697

FILED JUL 17 1943 318

Primary Registration District No.

1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis City Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 Days  
 (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT FULL NAME Mathilda M. Williams

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Charles 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased July 25 1878  
 (Month) (Day) (Year)

8. AGE: Years 64 Months 11 Days 14  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business Unknown

12. Name Unknown

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

14. Maiden name Unknown

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

(a) Informant Mrs. Cecilia Schwartz

(b) Address 2657 Marion St.

(c) Burial (b) Date thereof 7/12/43  
 (Burial, cremation, or removal) (Month) (Day) (Year)

Place: burial or cremation Calvary

Signature of funeral director J. L. Moyall

Address 1926 Allen Ave.

JUL 11 1943 (b) J. P. Bredesch  
 (Date received local registrar) (Registrar's signature)

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. 1014 Chouteau  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9,  
 year 1943 hour 4:55 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from July 7, 1943, to July 9, 1943.

that I last saw her alive on July 9, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Cardio-Vascular Disease

Due to Cerebral Thrombosis (old)

Due to Atherosclerosis of Basilar artery

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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

Of autopsy as above

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) None

(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 William D. Park (M. D. or other) 7/9/43  
 Address 1515 Lafayette Avenue Date signed \_\_\_\_\_

BLACK INK—MAKE A PERMANENT RECORD

OTHER

**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 me

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

working under my personal supervision.

Signed

W. M. Davis

Licensed Embalmer No.

8741

P. O. Address

1926a

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

**If this body is not embalmed, fact should be so stated above.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 23668Registration District No. 318Primary Registration District No. 1003Registrar's No. 6284

## 1. PLACE OF DEATH:

- (a) County.....St. Louis  
 (b) City or town.....St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:

(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.....Mathilda M. Wilkerson

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

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

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

7. Birth date of deceased.....July 25  
 (Month) (Day) (Year)

8. AGE: Years.....64 Months.....11 Days.....  
 If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

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

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

16. (a) Informant.....

- (b) Address.....

- (a) (Burial, cremation, or removal) (b) Date thereof.....  
 (Month) (Day) (Year)

Place: burial or cremation.....

17. (a) Signature of funeral director.....

- (b) Address.....

18. (a) SEP 20 1943 (b) J. F. Brubaker  
 (Date received local registrar's certificate) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....

- (c) City or town.....  
 (If outside city or town limits, write "RURAL")

- (d) Street No..... (If rural, give location)

- (e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day.....  
 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....;  
 that I last saw him....., 19.....;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

Duration

- Due to.....

- Due to.....

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

Major findings:  
 Of operations.....

Of autopsy.....

## PHYSICIAN

Underline  
 the cause to  
 which death  
 should be  
 charged sta-  
 tistically.

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..... (M. D. or other).....

Address..... Date signed.....

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

MOTHER FATHER

SUPPLEMENTARY

S-23658