

No. 2
4-12-39
5-17-39
X2315

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23661

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6578

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: Announced dead at Homer Phillips
(If not in hospital or institution, write street number or location) Home
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL") 22
(d) Street No. 2239 1/2 Walnut
(If rural, give location) 0
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19th
year 1943 hour 12:16 minute _____ A. M.
21. I hereby certify that I attended the deceased from _____
_____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Interstitial Nephritis;
Hypostatic Congestion of Both Lungs;
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? _____
(Specify type of place) _____
(e) Means of injury _____
While at work? _____
23. Signature Thomas F. Callahan (M. D. or other) _____
Address Deputy Coroner Date signed 7-21-43

3. (a) PRINT FULL NAME Arthur Williamson
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race col 6. (a) Single, widowed, married, divorced 9

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

7. Birth date of deceased Aug 12 1908
(Month) (Day) (Year)

8. AGE: Years 54 Months 11 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Memphis Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation Hauling & Labor

11. Industry or business _____
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)

16. (a) Informant Helen Clay
(b) Address 2916 Delmar

17. (a) Burial (b) Date thereof 7/21/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Greenwood cemetery

18. (a) Signature of funeral director Anna Funeral Home
(b) Address 2-15 So. Jefferson

19. (a) JUL 21 1943 (Date received local registrar)
J. F. Brudeck (Registrar's signature)

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

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.....

Licensed Embalmer No. *2698*

P. O. Address *2769 Shreve*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

AL 2 19

Registration District No. 218Primary Registration District No. 1003Registrar's No. 6578

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 Homer Phillip Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days3. (a) PRINT FULL NAME Arthur Williamson

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

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

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 54 Months 11 Days 12 Unless than one day _____ min.

9. Birthplace _____ (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 _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (c) _____
(Date received local registration) (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 July 1943
year 1943 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ alive on _____ 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 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-23661