S. No. 2
DM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 9 1943

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37995

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 1081

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: 2831a Franklin ave (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community 5 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St Louis (If outside city or town limits, write "RURAL") 21 000 17 9

(d) Street No. 2831a Franklin (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) No

If yes, name country _____

3. (a) PRINT FULL NAME SIGNORIA WILLIAMS

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 3

5. Color or race C

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____

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

7. Birth date of deceased JAN. (Month) 17 (Day) 1897 (Year)

8. AGE: Years 46 Months 10 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace unknown (City, town, or county) N. C. (State or foreign country)

10. Usual occupation Domestic

11. Industry or business _____

MOTHER FATHER

12. Name Peter Anderson

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

14. Maiden name Joseph unknown

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

16. (a) Informant Hattie White

(b) Address 2530 Adams St. Gary Ind.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11 29 43 (Month) (Day) (Year)

(c) Place: burial or cremation Edwards Mins

18. (a) Signature of funeral director J. J. Walton

(b) Address 2707 Stoddard St.

19. (a) NOV 29 1943 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25 year 1943 hour _____ minute 1 A. M.

21. I hereby certify that I attended the deceased from Nov. 23, 1943 to Nov. 25, 1943 that I last saw her alive on Nov. 24, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	2 days
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? _____ (Specify type of place)

While at work _____ (e) Means of injury _____

23. Signature W. H. G. Clark (M. D. or other)

Address 2748a Franklin Date signed 11-27-43

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(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 .....

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

working under my personal supervision.

Signed James A. Ohnson

Licensed Embalmer No. 3522

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.