

FILED MAY 2 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3676

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: Children Hospital
 (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 _____ (Specify whether years, months or days)

3. (a) PRINT Wife of
FULL NAME Bessie Gert Williams

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

4. Sex F 7. Color or race Col 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased April 15 1944
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
5 hr. min.9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Cecilia Williams13. Birthplace St. Louis 0
(City, town, or county) (State or foreign country)14. Maiden name Clea Williams15. Birthplace St. Louis 0
(City, town, or county) (State or foreign country)16. (a) Informant Clea Williams(b) Address 2731 Dayton17. (a) Burial (b) Date thereof 4-20-44
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Washington Park18. (a) Signature of funeral director Wright's Funeral Home(b) Address 3100 Eastern Ave19. (a) APP (b) J. F. Busch
(Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2731 Dayton 27
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1944 hour 6 minute A M.21. I hereby certify that I attended the deceased from 4-16-44
_____, 19____, to 4-20-44, 19____;
that I last saw her alive on 4-20-44, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Prematurely

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 R. J. Blotner (M. D. or other) _____Address Dr. H. Campbell Date signed _____

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.....

No Embalming

Licensed Embalmer No.....

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.