

FILED AUG 8 1944

Registration District No. 512

Primary Registration District No. 1003

Registrar's No. 6599

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:
Res: 5232 Enright Avenue.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County 11
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL") 912
(d) Street No. 5232 Enright Avenue.
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July, day 27th,
year 1944, hour 5:45 minute A. M.
21. I hereby certify that I attended the deceased from.....
19..... to 7-27- 19 44

that I last saw h alive on 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial asthma Duration 4 year

Notes: - O. Williams has been under care of Dr. C. M. MacPegley since 10-3-40.

Other conditions (Include present only within 3 months of death)
Major findings: Of operations 106
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 J. F. Biedeck (M. D. or other) M.D.
Address 3720 Washington St. Date signed 7/27/44

3. (a) PRINT FULL NAME ORIEW WILLIAMS.

3. (b) If veteran, name war none. 3. (c) Social Security No. none.

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

6. (b) Name of husband or wife Stella Williams. 6. (c) Age of husband or wife if alive 57. years

7. Birth date of deceased March 29, 1884.
(Month) (Day) (Year)

8. AGE: - Years Months Days If less than one day
60. 3. 28. hr. min.

9. Birthplace Allendale, Illinois.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired.

11. Industry or business Granitoid Contractor.

MOTHER FATHER { 12. Name Edgar Williams.

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

14. Maiden name Mary Stone.

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

16. (a) Informant Mrs Stella Williams.

(b) Address 5232 Enright Ave.,

17. (a) Cremation. (b) Date thereof 7/29/44.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Crematory.

18. (a) Signature of funeral director C. R. Lupton & Sons.

(b) Address #7233 Delmar Bldg.

19. (a) J. F. Biedeck (b) J. F. Biedeck
(Date received local registrar) (Registrar's signature)

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

Dr. B. Y. Glassberg.
3720 Washington.
FR: 0610.
Hrs.: 2 - 4: P.M.

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 *Bradford A. Miles*.....

Licensed Embalmer No. *2901*.....

P. O. Address *University City*.....

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.