

S. No. 2
DOM-5-43
ev. 5-17-39
I X36871

State File No.

FILED JAN 20 1945
318

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 116

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 19 days
(Specify whether years, months or days)

In this community 13 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 2310 Franklin
(If rural, give location) 219

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Samuel Willison

3. (b) If veteran, No name war No

3. (c) Social Security No. 18

4. Sex Male race colored

5. Color re

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

6. (b) Name of husband or wife unk

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

7. Birth date of deceased Not Known
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 1,
year 1945 hour 8 minute 40 A.M.

21. I hereby certify that I attended the deceased from November 23,
19 44 to January 1, 19 44,
that I last saw him alive on January 1, 19 44
and that death occurred on the date and hour stated above.

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

About 26 hr. min.

Immediate cause of death Far advanced Pulmonary Tuberculosis Duration Unk.

Due to 1/3

Due to 1/3

Other conditions 1/3
(Include pregnancy within 3 months of death)

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

10. Usual occupation Laborer

11. Industry or business not known

12. Name Not Known

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

14. Maiden name Not Known

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations 1/3

Of autopsy 1/3

MOTHER FATHER

16. (a) Informant Mary Jackson

(b) Address 2301 Franklin Ave

17. (a) Burial (b) Date thereof Jan 5, 1945
(Burial, cremation, or removal) (City or town) (County) (Month) (Day) (Year)

(c) Place: burial or cremation A. L. Seal and Co.

18. (a) Signature of funeral director 2726 LUCAS AVE.

(b) Address 2726 LUCAS AVE.

19. (a) JAN 6 1945 (Date received local registrar)

J. F. Bredek (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0

While at work? 0 (Specify type of place) (e) Means of injury 0

23. Signature Alvin Mason (M. D. 0)
Address 2601 W. 11th St. Date signed 1/2/45

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard,

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.