

Registration District No. **818** Primary Registration District No. **1003**

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

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:
1014a Chouteau 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)

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")
 (d) Street No. 1014a Chouteau Ave.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Charles Williams
 3. (b) If veteran, name war _____
 3. (c) Social Security No. 499-01-4670

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Mathilda Williams
 6. (c) Age of husband or wife if alive --- years
 7. Birth date of deceased Unknown about 1883
(Month) (Day) (Year)

8. AGE: Years About 62 Months Unknown Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name Charles Williams

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

14. Maiden name Williams

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

16. (a) Informant Cecelia Schwartz

(b) Address 265 Sims, Overland, Mo.

17. (a) Burial (b) Date thereof 4/4/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Wm G Myrdal
 (b) Address 1926 Allen Ave.

19. (a) APR 4 1945 (b) J. F. Brudek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2
 year 1945 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from 3-30-45 to 4-2-45
 that I last saw him alive on 4-2-45
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
 Duration _____

Due to _____
 Due to _____

Other conditions 108
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

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) (c) Means of injury _____

23. Signature R. P. Kleppel M. D. of other _____
 Address 905 Morris Date signed 4/3/45

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed D. M. Davis

Licensed Embalmer No. 3741

P. O. Address 1926 Allen Ave

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.