

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 8300  
Registrar's No. 2161

FILED MAR 16 1945

Registration District No. 318 Primary Registration District No. 1003

17  
9

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:  
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. 13 days  
(Specify whether)

In this community 30 years  
years, months or days

3. (a) PRINT FULL NAME Frank Williams

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male 5. Color or race Col

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 14 years (Year) 1895

7. Birth date of deceased. Nov 14 (Month) (Day) 1895 (Year)

8. AGE: Years 49 Months 11 Days 17 If less than one day hs. min.

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

10. Usual occupation Labour

11. Industry or business

12. Name Urban

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

14. Maiden name Urban

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

16. (a) Informant Rosie Jenkins

(b) Address 1012 N. Channing Ave

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-7-45 (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis

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

(b) Address 3517 Sialade Ave

19. (a) MAR 6 1945 (Date received local registrar) J. J. Bredek (Registrar's signature)

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") 21

(d) Street No. 111 N. Channing  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1,  
year 1945 hour 6 minute 35 A. M.

21. I hereby certify that I attended the deceased from January  
16, 1945, to March 1, 1945;  
that I last saw him alive on March 1, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Arteriosclerotic Heart Disease

Duration Unk.

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)

(c) Means of injury \_\_\_\_\_

23. Signature B. F. Myer (M. D. or other) 0

Address 3601 Whittier Date signed 3/1/45

**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 *R. M. Green*.....

Licensed Embalmer No. *1173*.....

P. O. Address *3517 Gulde 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.**