

V. S. No. 2
FORM-2-43
Rev. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

22207

6525

FILED AUG 3 1945

818

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(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:
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., 4 days
(Specify whether Life)

In this community Life
years, months or days

3. (a) PRINT FULL NAME William Levison

3. (b) If veteran, name war _____

3. (c) Social Security No. 500-18-3229

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife Alice Levison

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased January 14 1889
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>56</u>	<u>6</u>	<u>9</u>	hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Janitor

11. Industry or business Unavailable

MOTHER FATHER

12. Name Unavailable

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

14. Maiden name Unavailable

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

16. (a) Informant Mrs. Alice Levison

(b) Address 4204 Papin Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-45
(Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4127 Finney Ave.

19. (a) III 26 1945 (Date received local registrar) (b) J. F. Braddock (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")

(d) Street No. 4204 Papin St.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23,
year 1945 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from June 19, to July 23, 1945,
that I last saw him alive on July 23, and that death occurred on the date and hour stated above.

Immediate cause of death Pleurisy (prob. Tuberculous)

Due to _____

Due to _____

Other conditions: 1/2
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration Unk.

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 B. F. Murphy (M. D. coroner)
Address 2601 N. Whittier Date signed 7/23/45

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

STATEMENT BY LICENSED EMBALMER

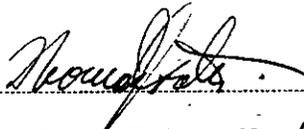
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Thomas J. Gates,

Registered Apprentice No.....

working under my personal supervision.

Signed.....



Licensed Embalmer No. 4259

P. O. Address 4107 Finney 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.