

**FILED** AUG 3 1945  
**378**

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

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

**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:  
Homer G. Phillips Hospital **0**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos. 5 days  
(Specify whether years, months or days)

In this community 30 years

**3. (a) PRINT FULL NAME** William Page

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 2

5. Color or race Colored

6. (a) Single, widowed, married, divorced, Widower 2

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: April 15, 1890  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>55</u>	<u>3</u>	<u>1</u>	hr. _____ min. _____

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

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name Booker Page

13. Birthplace Onio 1  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Shirley M. Smith

(b) Address Homer G. Phillips Hospital

17. (a) Burial (b) Date thereof 7-26-45  
(Burial, cremation or other) (Month) (Day) (Year)

(c) Place of burial or cremation Anatomical Dept

18. (a) Signature of funeral director W. R. K... 3500 Ridge

(b) Address \_\_\_\_\_

19. (a) JUL 30 1945 (Date received local registrar)

J. F. Bebech (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 000

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

(d) Street No. 4300 St. Ferdinand 9 11  
(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 16, year 1945 hour 5 minute 45 A. M.

21. I hereby certify that I attended the deceased from May 11, 1945 to July 16, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Heart Disease with congestive failure

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: 93  
(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)

(e) Means of injury \_\_\_\_\_

23. Signature B. F. Murphy (M. D. or other)

Address 2601 N. W. ... Date signed 7/19/45

Duration Unk.

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**