

FILED AUG 24 1945

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 hrs  
In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St Louis 17 21  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1023 N. Compton ave  
(If rural, give location)  
(e) Citizen of foreign country? 0  
(Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Harold Williams

3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Baby

6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive, years

7. Birth date of deceased June 9th 1945  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
2 3 hr. min.

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

10. Usual occupation Baby

11. Industry or business

12. Name Arvel Williams

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

14. Maiden name Marie Long

15. Birthplace St. Louis mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Marie Williams

(b) Address 1023 N. Compton ave

17. (a) Burial (b) Date thereof 8-13-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director H. Randle

(b) Address 3133 Beech ave

19. (a) AUG 13 1945 (b) J. F. Breese  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12 year 1945 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above

Immediate cause of death Heart failure Duration  
mal nutrition

Due to \_\_\_\_\_  
Due to 119

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?

(Specify type of place) 3  
While at work? (c) Means of injury  
Signature Dr. Taylor (M.D. or other)  
Address 1300 Clark Date signed 8-13-45

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

MOTHER FATHER

000  
17  
9

**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.

*not embalmed*  
Signed..... *J. R. Kandle*.....  
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.**