

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

DEPARTMENT OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS  
FILED SEP 28 1945 STANDARD CERTIFICATE OF DEATH  
318  
Registration District No. Primary Registration District No. 1003

State File No. 29485  
Registrar's No. 8155

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer H. Phillips  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1426 Cass  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME FRED WILLIAMS  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 15  
year 1975 hour 11 minute 51 P. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Lillie Mae Williams 6. (c) Age of husband or wife if alive 47 years  
7. Birth date of deceased Nov 19 1899  
(Month) (Day) (Year)

Immediate cause of death Cerebral Embolism  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) gob

8. AGE: Years 45 Months 9 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Ark.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Laborer

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Rafe Williams  
13. Birthplace Ark.  
(City, town, or county) (State or foreign country)  
14. Maiden name Roxie Siot  
15. Birthplace Ark.  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

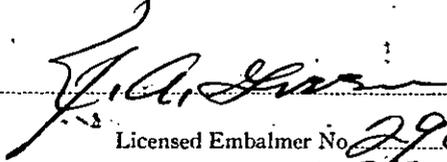
16. (a) Informant John H. Williams  
(b) Address 2224 E. Cass  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20/45  
(Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park Cem  
18. (a) Signature of funeral director F. A. Green  
(b) Address 2915 Franklin Ave.  
19. (a) SEP 19 1945 (Date received local registrar) (b) [Signature] (Registrar's signature)

23. Signature [Signature] (Specify type of place) (c) Means of injury \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

**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.

2963

P. O. Address

2915 Franklin 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.**