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ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 22 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

34237

State File No. 43-[illegible]

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2288

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Koch Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 505 dys (Specify whether
In this community 33 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County — 000

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

(d) Street No. 3807a Finney 9
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 1

If yes, name country —

3. (a) PRINT FULL NAME Clarence Williams

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex M 2

5. Color or race N

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

6. (b) Name of husband or wife —

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

7. Birth date of deceased 11 (Month) 29 (Day) 09 (Year)

8. AGE: Years 35 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Vicksburg (City, town, or county) Miss 1 (State or foreign country)

10. Usual occupation Chauffeur

11. Industry or business —

FATHER
12. Name Robert Williams
13. Birthplace Vicksburg (City, town, or county) Miss 1 (State or foreign country)

MOTHER
14. Maiden name Alberta Hardy
15. Birthplace Vicksburg (City, town, or county) Miss 1 (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Koch, Hosp, Koch, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15,45 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director Dement & Son
(b) Address 2629-31 Cole Street

19. (a) 10-15-45 (Date received local registrar) (b) E. G. McGovern M.D. M.S. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 11
year 45 hour 1 minute 30 A M.

21. I hereby certify that I attended the deceased from 5-16-, 1945, to 10-11-, 1945;
that I last saw him alive on 10-11-, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	22 mths (?)
Due to: 13	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature K. R. Engleman M.D. (M.D. or other)

Address Koch Hosp, Koch, Mo Date signed 10/11/45

(Licensed Embalmer's Statement on Reverse Side)

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4576 Aldine

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.