

FILED DEC 7 1945
318

Primary Registration District No. 1003

Registrar's No. 10324

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 23 days
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1623 Carver Lane
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Raleigh Williams

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

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

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

7. Birth date of deceased: June 15 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 10 hr. min.

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

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER

12. Name Abner Williams

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

14. Maiden name Carrie Williams

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

16. (a) Informant Mrs. Carrie Williams

(b) Address 1623 Carver Lane

17. (a) Burial (b) Date thereof 11-29-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

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

(b) Address 4107 Finney Ave.

19. (a) NOV 29 1945 (Date received local registrar) J. F. Bresick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25
year 1945 hour 3 minute 10 M.

21. I hereby certify that I attended the deceased from 11-2, 1945, to 11-25, 1945.
that I last saw him alive on 11-25-, 1945.
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia
Primary

Duration Unk

Due to _____

Due to _____

Other conditions: None
(Include pregnancy within 3 months of death)

Major findings: 107
Of operations _____

Of autopsy Yes

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 J. O. Blevins (M. D. or other) 11/29/45
Address 7601 N. Whittier Date signed

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

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17
9

STATEMENT BY LICENSED EMBALMER

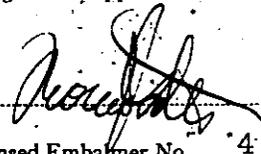
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

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.