

S. No. 2  
OM-8-43  
v. 5-17-39  
I X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

19059

State File No.

FILED MAY 27 1946 STANDARD CERTIFICATE OF DEATH

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 4321

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: Bethesda General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 weeks  
(Specify whether  
In this community 2 yrs 2 mo  
years, months or days)

3. (a) PRINT

FULL NAME Mollie Williams

3. (b) If veteran,

name war. No

3. (c) Social Security

No. No

4. Sex F / 5. Color or  
race W

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

6. (b) Name of husband or wife  
David Williams

6. (c) Age of husband or wife if  
alive 18 years

7. Birth date of deceased May  
(Month)

18  
(Day)

1864  
(Year)

8. AGE: Years 81 Months 11 Days 24

If less than one day  
hr. 25 min.

9. Birthplace Cumberland Gap Tenn  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business None

MOTHER FATHER { 12. Name John Wright

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

14. Maiden name Elizabeth Chumbley

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

16. (a) Informant Mrs. Vivian Watson

(b) Address 420 Georgia Ferguson Mo

17. (a) Burial (b) Date thereof 5-14-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salem, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) May 12 1946 (b) J. F. Bredeek  
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dent 3  
(c) City or town Salem NR/  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12<sup>th</sup>  
year 1946 hour 8 minute 25 A.M.

21. I hereby certify that I attended the deceased from MARCH  
26<sup>th</sup>, 1946, to MAY 12<sup>th</sup>, 1946  
that I last saw her alive on MAY 12<sup>th</sup>, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death —  
Hypostatic PNEUMONIA

Due to Squamous cell CARCINOMA  
of SAGE.

Due to 52  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

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 George D Mohr (M. D. or other) MD  
Address Bethesda Gen. Hosp Date signed 5-12-46

(Licensed Embalmer's Statement on Reverse Side)

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

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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 E. W. Wilkinson

Licensed Embalmer No. 3575

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.**