S. No. 2
M—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 7 1946

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35722

Primary Registration District No. 1003

Registrar's No. 9087

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital - Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution premature (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 2 3000

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

(d) Street No. 2102 Lafayette Ave. 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Infant ~~BABY BOY~~ WILLIAMS

3. (b) If veteran, name war ---

3. (c) Social Security No. ---

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased September 29th, 1946 (Month) (Day) (Year)

8. AGE: Years | Months | Days 4 | If less than one day hr. min.

9. Birthplace St. Louis City Hospital 0
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business

FATHER 12. Name William Williams

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Thresa De Pew

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10-24-46 (Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director L. White

(b) Address City Hospital No 1

19. (a) 10-24-46 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 3rd year 1946 hour 1:10 minute A M.

21. I hereby certify that I attended the deceased from 9/29/46, 19..., to Oct. 3rd, 19 46 that I last saw him alive on Oct. 3rd, 19 46 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity | Duration

Due to

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? 0
(Specify type of place)

While at work (e) Means of injury

23. Signature Janet Talmadge, M.D. (M. D. or other)

Address 1515 Lafayette Date signed 10/3/46

(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.....

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.