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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 10 1947

**THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

3288

State File No. _____

Registration District No. 214

Primary Registration District No. 1003

Registrar's No. 1122

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:
1431a Rear Franklin Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
in this community Eighty One Years
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. 1431a Rear Franklin Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CAROLINE WILLIAMS

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

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased About 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Abt 86 hr. min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER

12. Name Rob Hampton

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

14. Maiden name Unknown

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

16. (a) Informant Willietta Clark

(b) Address 617 No. 16th St.

17. (a) Burial Greenwood Cemetery (b) Date thereof 2/4/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Bennie Love

(b) Address 3103 Washington Ave.

19. (a) Feb. 3, 1947 (b) J.G. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 30th,
1947 hour 8 minute 20A.M.

21. I hereby certify that I attended the deceased from
June 20, 1946 to Janu 30, 1947
that I last saw her alive on January 30, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Nephritis

Due to _____

Due to 131

Other conditions No
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy N.O.

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)

(Specify type of place) _____
While at work? (c) Means of injury _____

23. Signature J.T. Edwards (M. D. or other) _____

Address 1926 Franklin Date signed 1-20-47

ement on Reverse Side)

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

J.G. Bredeck
Embalmer's Signat

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 726
Registrar's No. 1122

Registration District No. 318 Primary Registration District No. 1003

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:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... years, months or days)

3. (a) PRINT FULL NAME Caroline Williams

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

4. Sex F 5. Color B 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 186 years

7. Birth date of deceased abt (Month) 186 (Day) (Year)

8. AGE: abt Years 86 Months Days If less than one day
.....hr.min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 2-3-1947 (b) J. F. Biedeck (Register's signature)
(Date received local registrar) (FEB 17 1947)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (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 1947 year 1947 hour 11 minute 0 M.

21. I hereby certify that I attended the deceased from 9 to 19 that I last saw him alive and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations.....

Of autopsy.....

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..... (M. D. or other)

Address..... Date signed.....

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

SUPPLEMENTARY

S-3288