

No. 2
-12-45
5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3290**

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **156**

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 days**
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Emma White Williams**

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

4. Sex **Female** 5. Color or race **C**
6. (a) Single, widowed, married, divorced **Widowed**

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

7. Birth date of deceased **May 16 1873**
(Month) (Day) (Year)

8. AGE: Years **73** Months **7** Days **19**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Richard Jones**

13. Birthplace **Unknown Tenn.**
(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 **Albert White**

(b) Address **4222 E. Aldine Ave.**

17. (a) **Burial** (b) Date thereof **1-9-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

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

(b) Address **4107 Finney Ave.**

19. (a) **JAN 7 1947** (b) **J. F. Predeck**
(Date received local registrar) (Registrar's signature)

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. **4222 Aldine**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **5**
year **1947** hour **9** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **12-29-** 19 **46** to **Jan. 5** 19 **47**
that I last saw him alive on **Jan. 5** 19 **47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Degenerative Heart Disease**
Duration **Undet.**

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy **No**

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 **E. B. Williams** (M. D. or other) **0**
Address **2601 N Whittier** Date signed **1/7/47**

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

MOTHER FATHER

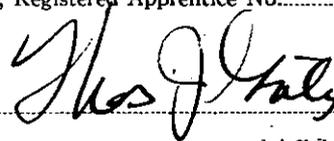
STATEMENT BY LICENSED EMBALMER

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 ~~XXXXXXXXXXXX~~
working under my personal supervision.

Registered Apprentice No.

Signed.....



Licensed Embalmer No. ~~XXXX~~ 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.