

No. 2
9-4-41
5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 14 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

11704

State File No. _____

Registrar's No. **3364**

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County **St. Louis, Mo.**
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer P. Philip
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1323 1/2 prairie**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

James J. Williams
3. (a) PRINT FULL NAME **JAMES J. WILLIAMS**

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

4. Sex **Male** 5. Color or race **negro**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Lula Williams** 6. (c) Age of husband or wife if alive **60** years
7. Birth date of deceased: **UNKNOWN**
(Month) (Day) (Year)

8. AGE: Years **About 67** Months **unknown** Days _____ If less than one day _____ hr. _____ min. _____

9. Birthplace: (City, town, or county) _____ (State or foreign country) **9**

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER { 12. Name **UNKNOWN**
13. Birthplace **Texas** (State or foreign country)
14. Maiden name **UNKNOWN**
15. Birthplace **UNKNOWN** (State or foreign country) **9**

16. (a) Informant **Lewis Williams**

(b) Address **1323 1/2 prairie**

17. (a) **BURIAL** (b) Date thereof **Mar. 29, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **H. H. Green**

(b) Address **2915 Franklin Ave.**

19. (a) **MAR 29 1947** (b) **J. F. Bredesch**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar. 24**, day _____, year **1947** hour **8** minute **30 A.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic Renal Vasculature Disease**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations _____
Of autopsy _____

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) _____
Means of injury _____

23. Signature **Wesley** (M. D. or other) _____
Address _____ Date signed **3/29/47**

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

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 G. A. Green
Licensed Embalmer No. 0963
P. O. Address 2915 Franklin

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.