FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAY 14 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15795

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 4586

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 10 days (Specify whether In this community years, months or days) 10 Years

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. 1118 N 13th St (If rural, give location)

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

If yes, name country U.S.A.

3. (a) PRINT FULL NAME Phillip Williams

3. (b) If veteran, name war None

4. (c) Social Security No. 499-01-1851

4. Sex Male 2

5. Color or race COL

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

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

6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased OCTober (Month) 10 th (Day) 1899 (Year)

8. AGE: Years 47 Months 6 Days 22 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Jim. Williams
13. Birthplace (City, town, or county) Miss. (State or foreign country)

MOTHER
14. Maiden name Cora. Washington.
15. Birthplace (City, town, or county) ? (State or foreign country)

16. (a) Informant Minnie Williams
(b) Address 1118 N 13 St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-7-47 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Lucie Walker
(b) Address 2829 Washington Blvd.

19. (a) MAY 6 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2 year 1947 hour 3 minute 15 P. M.

21. I hereby certify that I attended the deceased from 4-22, 1947, to 5-2, 1947 that I last saw him alive on May 2, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypertensive Heart Disease	Undet.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Cardiac Decompensation	

Major findings:
Of operations
Of autopsy None

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Edw B Williams (M. D. or other)

Address 7601 N Whittier Date signed 5/3/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

Licensed Embalmer No. 4441

P. O. Address 3959 Cook Av

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.