No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 7 1947 318

Registration District No.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. .35637

Registrar's No. 9931

1. PLACE OF DEATH:
(a) County: St Louis Mo
(b) City or town: (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2127 Cole St (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 7 Yrs. (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: 000
(c) City or town: St Louis (If outside city or town limits, write "RURAL") 17
(d) Street No.: 2127 Cole St. (If rural, give location) 9 0
(e) Citizen of foreign country? (Yes or No): 2
If yes, name country:

3. (a) PRINT FULL NAME: William E. Daniels
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: Male 2
5. Color or race: Col
6. (a) Single, married, widowed, divorced: Married
6. (b) Name of husband or wife: Lillie Daniels
6. (c) Age of husband or wife if alive: 53 years
7. Birth date of deceased: September (Month) 14 (Day) 1893 (Year)

8. AGE: Years 54 Months 1 Days 10 If less than one day hr. min.
9. Birthplace: Brookhaven (City, town, or county) Miss. (State or foreign country)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: William Daniels
FATHER 13. Birthplace: Hazelhurst (City, town, or county) Miss. (State or foreign country)
MOTHER 14. Maiden name: Annie Funches
MOTHER 15. Birthplace: Hazelhurst (City, town, or county) Miss. (State or foreign country)
16. (a) Informant: Lillie Daniels
(b) Address: 2127 Cole St.
17. (a) Burial, cremation, or removal: Removal (b) Date thereof: 10/30/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Brookhaven, Miss.
18. (a) Signature of funeral director: Ellis Fun. Home
(b) Address: 2820 Stoddard St
19. (a) Date received by local registrar: OCT 28 1947 (b) Registrar's signature: J. T. Breneck

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 24 year 1947 hour 4/50 minute P.M.
21. I hereby certify that I attended the deceased from Sept. 1 1947 to Oct. 24 1947 that I last saw him alive on Oct 24 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Endocarditis And Nephritis	About 4 Mos.
Due to: High blood pressure + Rheumatism	3 mos
Due to:	
Other conditions: Hemplegia (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

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: T. Jones (M. D. or other) 0
Address: 2330 [illegible] Date signed: 10/25/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

DEC 1 1947

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 Fulton E Culkin

Licensed Embalmer No. 4198

P. O. Address L L Lewis 13 M

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.