

S. No. 308  
M-10-47  
v. 5-17-39  
I 3906

FILED MAR 22 1948

State File No. \_\_\_\_\_  
Registrar's No. 786

Registration District No. 367

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Koch (rural)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Robert Koch Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 18 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME HANNAH, WILLIAM

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 490-01-6578

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lillie Harris (?) Hannah 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 23 1912  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	36	0	15	hr. _____ min.

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

10. Usual occupation Porter

11. Industry or business \_\_\_\_\_

12. Name Sidney Hannah

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

14. Maiden name Rosie Weatherov

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

16. (a) Informant Hospital Record  
(b) Address Koch Hospital

17. (a) Burial (b) Date thereof 3-17-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Ellis Funeral Home  
(b) Address 2820 Stoddard St

19. (a) 3-16-48 (b) Robert Koch Hospital  
(Date received local registrar) (Registrar's signature)

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")  
(d) Street No. 427 S. Ewing  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10  
year 1948 hour 7 minute A.M. M.

21. I hereby certify that I attended the deceased from 2-20-48, 19\_\_\_\_, to 3-10-48, 19\_\_\_\_;  
that I last saw him alive on 3-10-48, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 3 mo. (??)

Due to \_\_\_\_\_  
Due to 136

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) (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 John M. Beckham (M. D. or other) 0-2  
Address Robert Koch Hospital Date signed 3-10-48

MAR 24 1946

MAR 29 1946

**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. 498

P. O. Address St Louis 13 Mo

**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.**