

S. No. 300
M-10-47
5-17-39
I 396

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

14781

FILED APR 30 1948

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3883**

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: City Infy Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County One

(c) City or town ST, Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4167 Enright,
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Hattie Williams

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

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

7. Birth date of deceased Dec. 5 1887
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
year 1948 hour 9 minute 15A M.

21. I hereby certify that I attended the deceased from 7-1
47 1947 to 4-22 1948
that I last saw her alive on 4-22 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma - primary site undetermined Duration _____

8. AGE: Years 60 Months 4 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation Nil

Due to Bronchopneumonia

Due to Pulmonary infarct

Other conditions _____
(Include pregnancy within 3 months of death)

11. Industry or business _____

12. Name John

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

14. Maiden name Carrie Williams

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

Major findings: _____

Of operations _____

Of autopsy same

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

16. (a) Informant City Infirmiry Records

(b) Address 5800 Arsenal ST

17. (a) Burial (b) Date thereof 4-26-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Re J. P. ...

(b) Address 3615-17 Boston Ave.

19. (a) APR 24 1948 (Date received local registrar)

J. F. Brodick (Registrar's signature)

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 C

23. Signature Ward C. Lewis (M. D. or other) _____

Address 5600 Arsenal Date signed 4-23-48

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.....

J. E. Cooper....., Registered Apprentice No. *505*
working under my personal supervision.

Signed.....

[Signature]
Licensed Embalmer No. *4441*

P. O. Address. *2829 Washington*

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.