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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 6 1948

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21626
Registrar's No. 4480

Registration District No. 377

Primary Registration District No. 3070

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Webster Groves 19
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
309 Fairlawn
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 27 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Webster Groves 19
(If outside city or town limits, write "RURAL")
(d) Street No. 309 Fairlawn Ave.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME SAMUEL WILLIAMS D.D.S.
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Katherine Williams
6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased May 27 1859
(Month) (Day) (Year)

8. AGE: Years 89 Months 0 Days 15
If less than one day _____ hr. _____ min.

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

10. Usual occupation Dental Surgeon

11. Industry or business _____

12. Name Peter C. Williams

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

14. Maiden name ? Fearing

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

16. (a) Informant _____

(b) Address 309 Fairlawn Ave., Webster Groves, Mo.

17. (a) burial (b) Date thereof 6 15 '48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director Mittelberg Fun'l Home,

(b) Address Webster Groves 19, Mo.

19. (a) 6-14-48 (b) Beulah Sharpe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12
year 1948 hour 7 minute 00 p. M.

21. I hereby certify that I attended the deceased from 3/8, 1948, to 6/12, 1948,
that I last saw him alive on 6/12, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death Anemia
Due to Chronic glomerulo-nephritis
Due to Senility 1316
Other conditions (Include pregnancy within 3 months of death)

Duration 1 wk

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) (f) Means of injury _____
23. Signature John King (M. D. or other) _____
Address 671 E. Big Bend Rd Webster Groves Mo Date signed 6/14/48

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Gustav W. Deutel*
Licensed Embalmer No. *4329*
P.O. Address *St. Louis, 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.