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FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED SEP 13 1948  
318

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 28337

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 7647

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

1. PLACE OF DEATH:

(a) County St. Louis  
(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 21 days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3- (a) PRINT FULL NAME Obie Williams

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

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

6. (b) Name of husband or wife Unk 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years 58 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Nil

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

12. Name Not known

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

14. Maiden name Not known

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

16. (a) Informant Elizabeth Rhodes

(b) Address 2601 N Whittier St

17. (a) Anatomical Board Date thereof 8-31-48  
(Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service  
4104 Manchester Ave.

(b) Address \_\_\_\_\_

19. (a) 8-31-48 (b) J. F. Bradeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2315 Walnut St  
(If rural, give location)  
(e) Citizen of foreign country? 22 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20 year 1948 hour 2 minute 10 a. m.

21. I hereby certify that I attended the deceased from June 29, 1948, to July 20, 1948  
that I last saw him alive on July 20, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of the Lungs Duration \_\_\_\_\_

Due to Undetermined

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

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

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

Of autopsy None

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 Oscar L Daniels (M. D. or other) \_\_\_\_\_

Address 2601 N Whittier Date signed 7/22/48

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

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**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.....

P. O. Address.....

**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.**