FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

1003

State File No. 38796

Registration District No. FILED DEC 2 1948 318

Primary Registration District No.

Registrar's No. 10149

1. PLACE OF DEATH:

(a) County

(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 Infirmary
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Yrs 5 Mo. 1 day (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

(c) City or town 5800 Arsenal St.
(If outside city or town limits, write "RURAL")

(d) ~~Street No.~~ St. Louis
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME FRANK 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 single

6. (b) Name of husband or wife

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

7. Birth date of deceased January (Month) 4, (Day) 1880 (Year)

8. AGE: Years 68 Months 10 Days 18 If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business

FATHER
12. Name Joe Williams
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mandy Donaldson
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant City Infirmary
(b) Address 5800 Arsenal St.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/23/48 (Month) (Day) (Year)
(c) Place: burial or cremation Green Wood Cem.

18. (a) Signature of funeral director Lee J. Speed
(b) Address 3615-17 Easton Ave

19. (a) NOV 23 1948 (Date received local registrar) (b) J. B. Lasker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 22
year 1948 hour 12 minute 00 A. M.

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

	Duration
Immediate cause of death ARTERIOSCLEROTIC HEART DISEASE	
Due to	
Due to	
Other conditions OLD ENCEPHALOMALACIA (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy SAME

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 Palmer Prussine Bowdish (M. D. ~~or other~~)
Address 5600 Arsenal St. Date signed 11/23/48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Not Embalmed

Charles L. Taylor

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Due

Registration District No. 314 Primary Registration District No. 1003 Registrar's No. 10149

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

(b) City or town
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Frank William

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive (Year)

7. Birth date of deceased Jan 4 (Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days 14 If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 12-6-48 (Date received local registrar) (b) J. B. Lasater (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month year 1948 day 22 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

38796