

FILED JUN 15 1951

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BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place) 2169	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters of the Poor 3400 S. Grand Blvd.		d. STREET ADDRESS (If rural, give location) 3400 S. Grand Blvd.	

3. NAME OF DECEASED (Type or Print) John H. Williams			4. DATE OF DEATH (Month) (Day) (Year) May 28, 1951		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH August 11, 1876		9. AGE (In years last birthday) Months Days 74 9 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape Gardener		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mexico Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John Williams		13b. MOTHER'S MAIDEN NAME Annie Sorbury		14. NAME OF HUSBAND OR WIFE Frances Mines Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sister Henry 3400 S. Grand		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Haemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis		3 yrs	
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X			

22. I hereby certify that I attended the deceased from **Apr 27, 1951**, to **May 1, 1951**, that I last saw the deceased alive on **May 1, 1951**, and that death occurred at **7 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Deceased or title) John H. Williams		23b. ADDRESS 607 N. Grand		23c. DATE SIGNED 1951	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/21/51	24c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem	24d. LOCATION (City, town, or county) (State) 7030 Gravois St. Louis Mo		

DATE REC'D BY LOCAL REG. MAY 29 1951	REGISTRAR'S SIGNATURE J. B. Farsten	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Gebken Sons 2630 Gravois	
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WRITE PLAINLY—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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Robert F. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois

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.