

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REC'D FEB 10 1939

791
1008

721
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City St. Louis (d) Street No. Park Lane Hospital Registered No. 721
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

45 Anna L. Williams (Baker)
 (a) Residence, No. 322 N. 6th St. St. NR East St. Louis Ill.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Madell Williams

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 6, 1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
41 10 16

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Restaurant
 9. Industry or business in which work was done, as saw mill, bank, etc. Proprietor
 10. Date deceased last worked at this occupation (month and year) Jan. 15, 1939 11. Total time (years) spent in this occupation 30

12. BIRTHPLACE (CITY OR TOWN) Jacksonville
 (STATE OR COUNTRY) Ill.

FATHER 13. NAME Frank Goolsby

14. BIRTHPLACE (CITY OR TOWN) Illinois
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Nettie Riley

16. BIRTHPLACE (CITY OR TOWN) Illinois
 (STATE OR COUNTRY)

17. INFORMANT Mrs. Nettie Goolsby
 (ADDRESS) 322 N. 6th St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Valhalla Cem. DATE 1-25 1939

19. FUNERAL DIRECTOR (NAME) Kriegshauser Mortuary
 (ADDRESS) 4228 So. Kingshighway

20. FILED JAN 24 1939
J. O. Bucher Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 22 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1939, to Jan. 22, 1939
 I last saw him alive on Jan. 21, 1939. Death is said to have occurred on the date stated above, at 3:30 P.M.
 The principal cause of death and related causes of importance were as follows:

Peritonitis Date of onset 1-5

Other contributory causes of importance:
Saw piece abscess
due to prostate pro-
stata caused by old
abscess
 Name of operation prostatectomy Date Jan 15, 1939
 What test confirmed diagnosis? physical Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) John J. Smith M. D.
 (Address) 49 So. 8th St.

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 *Reinhold T. Lohmann*

Licensed Embalmer No. *3395*

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, above space should be left blank.