

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

7740  
Do not use this space.

96  
12  
2  
MAR 9 1939

1. PLACE OF DEATH  
 (a) County St. Louis Registration District No. 784  
 (b) Township Clayton Primary Registration District No. 101 Registered No. 369  
 (c) City Clayton (d) Street No. St. Louis County Hospital St.  
 (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 Martha Williams  
 (a) Residence, No. 9900 S. Broadway, LeMay, Mo. (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) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 19, 1900

7. AGE YEARS 39 MONTHS 0 DAYS 8 IF LESS than 1 day, .....hrs. or .....min.

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

FATHER  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.  
 13. NAME George Miller  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

MOTHER  
 15. MAIDEN NAME Anna Frolley  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

17. INFORMANT husband, Walter Williams  
 (ADDRESS) 9900 S. Broadway, LeMay, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE National Cem. DATE Mar 2 1939

19. FUNERAL DIRECTOR (NAME) C. Hoffmeister  
 (ADDRESS) 7814 S. B'way

20. FILED MAR 1 1939 D. R. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/27/39 1939

22. I HEREBY CERTIFY, That I attended deceased from 2/23/39 1939 to 2/27/39 1939.  
 I last saw her alive on 2/27/39 1939. Death is said to have occurred on the date stated above, at 4:50 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Heart Disease, Rheumatic Myocardial Failure  
 Date of onset 2/10/39

Other contributory causes of importance: None

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ 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 \_\_\_\_\_ 1939  
 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) James Dowd, M. D.  
 (Address) St. Louis County Hospital

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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 conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**