

REC'D APR 12 1939

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

791
1008

9234
Do not use this space.
2999

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No.....
(c) City St. Louis (d) Street No. City Hospital #1 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 James Williams

(a) Residence, No. 5800 Arsenal St. St. 13
(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 4, 1874.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
64 5 22

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
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.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

FATHER 13. NAME John Williams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know.

MOTHER 15. MAIDEN NAME Dont Know.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know.

17. INFORMANT M. Kent
(ADDRESS) City Hospital #1

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemetery DATE Mar. 31, 1939

19. FUNERAL DIRECTOR (NAME) J. H. Gebhard & Co
(ADDRESS) 2842 Meramec St.

20. FILED MAR 30 1939 J. B. [Signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/26, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 1:00 p. m.
The principal cause of death and related causes of importance were as follows:

Senile Dementia; Fracture of the left Arm; suffered in fall to the floor at the City Infirmary, about 1:00 P. M. March 14th, 1939.

Other contributory causes of importance:
Name of operation _____ Date of _____
Was test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide: Accident Date of injury 3/14/1939
Where did injury occur? St. Louis, Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. In Public Place

Manner of injury See Above
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify _____
(Signed) Joseph M. [Signature] M.D.
(Address) Deputy Coroner

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.

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.

Not Embalmed

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, above space should be left blank.