

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. THIS IS A PERMANENT RECORD

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

REC'D JUN 12 1939

791
 1008

16757
 Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No. **4291**
 (c) City **St. Louis Mo.** or (d) Street No. **Lutheran Hosp.** 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 **Sophie Williams**

(a) Residence, No. (Usual place of abode, if no street address, write county or city) St. **NR Festus Mo.**
 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **10th Aug 1868**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	70	8	26	

OCCUPATION 8. Trade, profession, or particular kind of work done, as lawyer, 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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Pevely Mo.**

FATHER 13. NAME **Louis Yeida**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

MOTHER 15. MAIDEN NAME **Kate Harrington**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Pevely Mo.**

17. INFORMANT (ADDRESS) **Thomas Williams Festus Mo.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Festus Mo.** DATE **5/9/39.**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **A. H. Hoppe 4700 Washington**

20. FILED **MAY 8 1939.** **J. D. Budick Local Registrar.**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 6th 39 19**

22. I HEREBY CERTIFY, That I attended deceased from **April 21**, 19**39**, to **May 6**, 19**39**
 I last saw her alive on **May 6**, 19**39** Death is said to have occurred on the date stated above, at **8 PM** m.
 The principal cause of death and related causes of importance were as follows:

Intestinal Hemorrhage due to Hepatic Carcinoid

Date of onset **Sept. 1938**

Other contributory causes of importance: **Carcinoma of Ovary with metastasis**

Name of operation **Exploration, Sections** Date of **4/23/39**
 What test confirmed diagnosis? **H&E** Was there an autopsy? **No**

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? **No**
 If so, specify (Signed) **Glewis Husted** M. D.
 (Address) **902 S. S. Nat. Bank Bldg**

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

Guy W. Wilkinson

Licensed Embalmer No.

3575

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.