

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

SEP 14 1939

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27631

State File No.

7131

Registrar's No.

Registration District No.

291

Primary Registration District No.

1. PLACE OF DEATH:

1003

- (a) County _____
 - (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 - (c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)
 - (d) Length of stay: In hospital or institution 3 Days
(Specify whether _____)
- In this community _____
years, months or days)

8. (a) PRINT FULL NAME James Williams 452

8. (b) If veteran, name war None 8. (c) Social Security No. Unk

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife TESS WILLIAMS 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased DEC. 10 1890
(Month) (Day) (Year)

8. AGE: Years 48 Months 8 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Unknown MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed Carpenter

11. Industry or business _____

MOTHER FATHER { 12. Name SAMUEL WILLIAMS

13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

14. Maiden name AMELIA BAUNDERS

15. Birthplace Unknown MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Tess Williams

(b) Address 3849 West Pine Blvd.

17. (a) Removal (b) Date thereof 8/18/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jefferson City Mo

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) AUG 16 1939 (b) J. P. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MISSOURI (b) County CITY OF ST. LOUIS
- (c) City or town 3849 WEST PINE
(If outside city or town limits, write "RURAL")
- (d) Street No. _____
(If rural, give location)
- (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15, year 1939 hour 5:40 minute P. M.

21. I hereby certify that I attended the deceased from August 13, 1939 to August 15, 1939 and that death occurred on the date and hour stated above.

that I last saw him alive on August 15, 1939 Immediate cause of death Cardio-vascular renal disease Duration _____

Due to Uremia

Due to _____

Other conditions (Include pregnancy within 8 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
- (b) Date of occurrence _____
- (c) Where did injury occur? _____
(City or town) (County) (State)
- (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (4) Means of injury

23. Signature Wm. Piper (M. D. or other) _____

Address City Hospital Date signed 8/16/39

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..... *Albert J. Hopper*.....

Licensed Embalmer No..... *2971*.....

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.