

JAN 12 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41614

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 10737

1. PLACE OF DEATH:

JAN 12 1940 /

(a) County St Louis  
(b) City or town \_\_\_\_\_  
(c) Name of hospital or institution: Homer G Phillips Hospital  
(If outside city or town limits, write "RURAL" and name of township)  
(d) Length of stay: In hospital or institution 16 days  
(Specify whether \_\_\_\_\_)  
In this community Unknown  
years, months or days

3. (a) PRINT FULL NAME Lillian Williams 452

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Johnnie Lee Williams 6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased 1 25 1918  
(Month) (Day) (Year)

8. AGE: Years 21 Months 10 Days 19 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Landcota Texas  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Walter Collins 9

13. Birthplace unknown ?  
(City, town, or county) (State or foreign country)

14. Maiden name Virginia ?

15. Birthplace unknown ?  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Johnnie Lee Williams

(b) Address 2827 Franklin Ave

17. (a) Burial (b) Date thereof 12/20/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director Ellis Funeral Home

(b) Address 2820 Stoddard St

19. (a) DEC 16 1939 (b) J. H. Bennett  
(Received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis 21  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2827 N Whittier Franklin Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 14 day 14  
year 1939 hour 2:00 minute 10 PM.

21. I hereby certify that I attended the deceased from November 29, 1939, to December 14, 1939,  
that I last saw her alive on December 14, 1939,  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 10 mos

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Hydropericardium Approx 1 mo  
(Include pregnancy within 6 months of death) Tuberculous Peritonitis " 1 mo

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) (e) Means of injury \_\_\_\_\_

23. Signature M. Walter Allen (M. D. or other) \_\_\_\_\_

Address 2601 N Whittier Date signed \_\_\_\_\_

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 *L. B. Boyer*

....., Registered Apprentice No. *Apply*  
working under my personal supervision.

Signed *L. B. Boyer*

Licensed Embalmer No. *294*

P. O. Address *St. Louis*

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.