

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

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

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County 1  
(b) City or town St. Louis  
(c) Name of hospital or institution:  
Homer Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 hrs (Specify whether  
In this community 19 yrs. years, months or days)

3. (a) PRINT FULL NAME Nancy Williams 453. (b) If veteran, name war nil 3. (c) Social Security No. nil4. Sex Fem 5. Color or race Col 6. (a) Single, widowed, married, divorced Widow6. (b) Name of husband or wife Lee Williams 6. (c) Age of husband or wife if alive Deceased years7. Birth date of deceased Abt. 1889 (October) (Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
Abt. 50 2 hr. min.9. Birthplace Union City Tennessee  
(City, town, or county) (State or foreign country)10. Usual occupation Housework (at home)

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

12. Name Miles Edmonds 913. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)14. Maiden name Unknown 9  
(City, town, or county) (State or foreign country)15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Lee Williams(b) Address 23 52 Charlotte ave.17. (a) Removal (b) Date thereof 11/21/39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Union City, Tennessee18. (a) Signature of funeral director J. M. Green(b) Address 3517 Soledad Ave19. (a) 11/21/1939 (b) J. J. [Signature]  
(Date of death) (Signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1  
(c) City or town St. Louis 22  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2352 Chouteau  
(If rural, give location)  
NO PHYSICIAN IN ATTENDANCE  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18th  
year 1939 hour 5:40 minute P. M.21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.Immediate cause of death Hemorrhage of Brain; (Apoplexy)  
Coronary Sclerosis; Duration \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: [Signature]  
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 423. Signature [Signature] (M. D. or other) \_\_\_\_\_Address [Signature] \_\_\_\_\_

**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.....

*W. M. Green*

Licensed Embalmer No. 1173

P. O. Address. 3517 Duclade Ave

**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.**