

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
JAN 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

41922

11045

Registration District No. 751

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County 2
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4406 Oakland Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis 18
(If outside city or town limits, write "RURAL")
4406 Oakland Ave.
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Emma Williams 452

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

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

6. (b) Name of husband or wife Late Fred Williams 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 16 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Terre Haute Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housework at home

11. Industry or business _____

MOTHER FATHER { 12. Name Wilson Lindsey

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

14. Maiden name Nancy Burt

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

16. (a) Informant's own signature Mrs. Maude Boothe

(b) Address 4406 Oakland Ave.

17. (a) Burial (b) Date thereof 12-28-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Clair Mo.

18. (a) Signature of funeral director Kriegshauser Mortuaries

(b) Address 4104 Manchester Ave.

19. (a) DEC 27 1939 (b) J. F. [Signature]
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 25th
year 1939 hour 7:15 minute P.M. M.

21. I hereby certify that I attended the deceased from 10-24-1936 to 12-25-1939

that I last saw her alive on 12-25-1939
and that death occurred on the day and hour stated above.

Immediate cause of death Chronic myocardial infarction

Due to _____

Due to _____

Other conditions Chronic Bronchitis
(Include pregnancy within 3 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)

(e) Means of injury _____

23. Signature E. D. Edwards (M. D. or other) _____

Address 4020 [Address] Date signed 12/26/39

Ne:0382

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.....

Eduard M. Bernath

Licensed Embalmer No.....

3024

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.