

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County  
(b) City or town St. Louis Mo.  
(c) Name of hospital or institution St. Louis Homeopathic Hosp.  
(d) Length of stay: In hospital or institution 30 years  
In this community 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County  
(c) City or town St. Louis Mo.  
(d) Street No. 2120<sup>a</sup> Spruce St.  
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26<sup>th</sup>  
year 1940 hour 3:55 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 Chronic Insufficiency of the Heart

Due to Myocardial Concentric Hypertrophy + Dilatation

Due to Left Ventricular Failure

Other conditions (include pregnancy within 3 months of death)

Major findings: Chronic Intermittent

Of atopsy 151 Rephutes

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) \_\_\_\_\_ (b) Means of injury \_\_\_\_\_

22. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3. (a) PRINT FULL NAME Grant Williams

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. NONE

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Gertha Williams 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased: July (Month) 13 (Day) 1882 (Year)

8. AGE: Years 57 Months 11 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Va. (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation Laborer

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

12. Name Paul Williams

18. Birthplace Va. (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name Mary Williams

15. Birthplace Washington D. C. (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Gertha Williams

(b) Address 2120<sup>a</sup> Spruce St.

17. (a) Burial (b) Date thereof 6-29-40 (Burial, cremation, or removal) \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Atkins Bros

(b) Address 3644 Frimley Ave

19. (a) JUN 28 1940 (Date received locally) \_\_\_\_\_ (b) J.F. Beduch (Registrar's signature)

JUL 29 1941

AUG 19 1941

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**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 Louis V. Atkins

Licensed Embalmer No. 2842

P. O. Address 3644 Finne

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.