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5-17-1927  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **33495**  
Registrar's No. **8192**

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

**NOV 16 1940** **791**  
Registration District No.

Primary Registration District No. **1003**

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_

(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo 27 das 2 1  
(Specify whether years, months or days)

In this community 4 years  
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Carr Williams

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased SEPT 15 1902  
(Month) (Day) (Year)

8. AGE: Years 38 Months 13 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace CLAYTON MO  
(City, town, or county) (State or foreign country)

10. Usual occupation COMMON LABORER

11. Industry or business UNK

12. Name of informant J. ANT WILLIAMS

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

14. Maiden name MARY BROOKS

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

16. (a) Informant Jean Williams

(b) Address 7713 Bohme Clayton - MO

17. (a) DIAL (Burial, cremation, or removal) (b) Date thereof OCT-2-1940  
(Month) (Day) (Year)

(c) Place burial or cremation WASHINGTON PARK Cem

18. (a) Signature of funeral director Walter Holman

(b) Address Home 3028 Dickson St

19. (a) OCT 2 1940 (Date received local registrar) (b) J. B. Beck (Signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St Louis 11  
(If outside city or town limits, write "RURAL")

(d) Street No. 442 Maffitt  
(If rural, give location)

(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28 year 1940 hour 3:15 minute \_\_\_\_\_ P M.

21. I hereby certify that I attended the deceased from July 31, 1940, to Sept 28, 1940, that I last saw him alive on Sept 28, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease Duration 2 1/2 years

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

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: NO Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

(Specify type of place)

Means of injury \_\_\_\_\_

23. Signature O. J. Allen (M. D. or other) \_\_\_\_\_  
Address 2601 N Whittier Date signed \_\_\_\_\_

**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

*H. A. Hester*

Licensed Embalmer No. 2963

P. O. Address 2965 Franklin

**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.**