

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 20153

4965

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

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

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

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:  
De Paul Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 hour  
(Specify whether  
 In this community 25 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5595 Chamberlain  
(If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14 year 1941 hour 7 minute 30 P. M.  
 21. I hereby certify that I attended the deceased from Aug 17 1940 to June 14 1941  
 that I last saw him alive on June 14 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis  
Chronic Myocarditis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Aug 17/40 Bronchitis, Pharyngitis  
(Include pregnancy within 6 months of death)  
 Major findings: resulting in Chronic Nephritis  
 Of operations: Bimboles  
 Of autopsy: no

Duration  
7 days  
Aug 17/40  
 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 Harry D Meyer (M. D. or other)  
 Address 4903 Delmar Date signed 6/16/41

3. (a) PRINT FULL NAME JACOB L. WILLIAMSON

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

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

6. (b) Name of husband or wife Alice H. 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased August 14 1864  
(Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Coterville Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Executive

11. Industry or business Advertising

12. Name James Pinkney  
 13. Birthplace Kansas  
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca Lindsay  
 15. Birthplace unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant J. S. Williamson

(b) Address 5595 Chamberlain

17. (a) burial (b) Date thereof 6/17/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Alexander

(b) Address 6175 Delmar Blvd.

19. (a) JUN 17 1941 (b) J. H. Bredeck  
(Date of local registrar) (Registrar's signature)

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

MOTHER FATHER

**STATEMENT BY LICENSED EMBALMER**

2

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.....

*Jos. E. McCulloch*

Licensed Embalmer No. *2460*

P. O. Address. *5170 Delmar*

**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, fact should be so stated above.**