

MISSOURI STATE BOARD OF HEALTH  
 STANDARD CERTIFICATE OF DEATH  
 1003

State File No. **33260**  
 Registrar's No. **8215**

Registration District No. **791**  
 Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County \_\_\_\_\_  
 (b) City or town St. Louis, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Mary's Infirmary  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 11 days  
 In this community 40 yrs.  
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME Ludelia Williams  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex F  
 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Luther  
 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
45 hr. min.

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

10. Usual occupation Housework

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

MOTHER FATHER { 12. Name Phillip Morton  
 { 13. Birthplace Wentzville Mo  
 { 14. Maiden name Dora Calloway  
 { 15. Birthplace UNKNOWN, Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant Luther Williams  
 (b) Address 2107 O'Fallon

17. (a) Burial (b) Date thereof 10-19-41  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hopewell, Missouri

18. (a) Signature of funeral director Bennie Lee  
 (b) Address 3103 Washington Avenue

19. (a) OCT 19 1941 (b) J. D. Bredsek  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County St. Louis  
 (c) City or town: Saint Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2107 O'Fallon  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 13, 1941  
 year \_\_\_\_\_ hour 2:30 A.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 10-2-41  
 \_\_\_\_\_, 1941, to October 13, 1941;  
 that I last saw her alive on October 13, 1941;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocarditis Duration 13 days  
 Due to Chronic myocarditis 1 yr.

Due to Hypertension 3 yrs.

Other conditions \_\_\_\_\_  
 (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 Walter C. Taylor (M, D. or other)  
 Address 3146a Laclede Ave. Date signed 10-15-41

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



MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33260

Registration District No. 791

Primary Registration District No. 1003

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: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)
  - (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether
- In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

- 3. (a) PRINT FULL NAME Ludelia Williams
- 3. (b) If veteran, name war \_\_\_\_\_
- 3. (c) Social Security No. \_\_\_\_\_

- MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct Day 23 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

- 4. Sex A
- 5. Color or race B
- 6. (a) Single, widowed, married, divorced m
- 6. (b) Name of husband or wife \_\_\_\_\_
- 6. (c) Age of husband or wife if alive \_\_\_\_\_ years
- 7. Birth date of deceased Unknown as to exact date  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE: Years 45 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ min.

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

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

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

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

10. Usual occupation \_\_\_\_\_

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

Major findings: \_\_\_\_\_

12. Name \_\_\_\_\_

Of operations \_\_\_\_\_

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

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

14. Maiden name \_\_\_\_\_

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

22. If death was due to external causes, fill in the following:

16. (a) Informant \_\_\_\_\_

- (b) Address \_\_\_\_\_

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

- (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

- (b) Address \_\_\_\_\_

19. (a) DEC 3 1941 (b) J F Brudeck  
(Date received local registrar) (Registrar's signature)

- (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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

1941

S-33260

8215  
0158-38