

No. 2  
1-4-41  
-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

39423

State File No. 2

DEC 13 1941

Registration District No. 54

Primary Registration District No. 200

Registrar's No. 2489

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Koch Cemetery  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Koch Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 63 days  
(Specify whether years, months or days)  
In this community 12 yrs

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. 2612 Market  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ERNESTINE WILLIAMS

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

4. Sex F 5. Color or race N 6. (a) Single, widowed, married, divorced U

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

7. Birth date of deceased Jan. 1, 1909  
(Month) (Day) (Year)

8. AGE: Years 32 Months 11 Days 5 If less than one day hr. min.

9. Birthplace Pine Bluff Ark.  
(City, town, or county) (State or foreign country)

10. Usual occupation Waitress

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

12. Name Samuel Williams

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

14. Maiden name Becky Cheeks

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

16. (a) Informant Elizabeth Brewer (sister)

(b) Address 2807 Thomas

17. (a) Burial (b) Date thereof 12-12-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem

18. (a) Signature of funeral director Chas Galia

(b) Address 4107 Finney Ave. St. Louis, Mo

19. (a) DEC 12 1941 (b) E. M. Gasquin  
(Date received local registrar) (Registrar's signature)

707 (Licensed Embalmers' Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6  
year 1941 hour 9:00 minute A. M.

21. I hereby certify that I attended the deceased from 10-3-41  
1941 to 12-6-41 1941  
that I last saw her alive on 12-6-41 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Pulmonary Tuberculosis Duration 6 mo.

Due to \_\_\_\_\_  
Due to 13/41  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy Chronic Pulmonary Tuberculosis

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 W. D. Rowland (M. D. or other) \_\_\_\_\_  
Address Koch Hospital Date signed 12-8-41

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

P  
5-4

DEC 15 1949

**STATEMENT BY LICENSED EMBALMER**

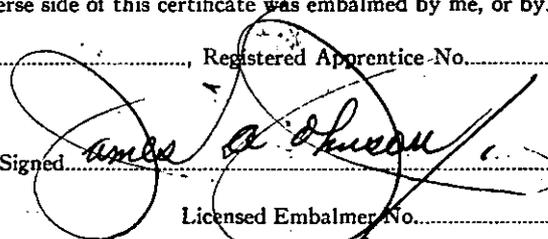
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James A. Johnson.....

Registered Apprentice No.....

working under my personal supervision.

Signed



Licensed Embalmer No..... 3522

P. O. Address..... 4107 Finney Ave.....

**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.**