

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

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State File No. \_\_\_\_\_  
Registrar's No. 5923

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 21 days  
 In this community 11 years 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3861 Bell  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Daisy Williams  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. 418-10-3859

4. Sex 3 F  
 5. Color or race col  
 6. (a) Single, widowed, married, divorced. 2  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 5 1902  
(Month) (Day) (Year)

8. AGE: Years 42 Months 5 Days 22  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Press Operator Laundry

11. Industry or business \_\_\_\_\_  
 12. Name Thomas Titurn  
 13. Birthplace Carrocton Mo  
(City, town, or county) (State or foreign country)  
 14. Maiden name Albert Swank  
 15. Birthplace unk Ky  
(City, town or county) (State or foreign country)

16. (a) Informant Leola Lumpskins  
 (b) Address 3861 Bell (18) Ave

17. (a) Burial (b) Date thereof 7-3-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. F. Brueck  
 (b) Address 3133 Bell Ave  
 19. (a) JUL 2 1944 (b) J. F. Brueck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION:

20. DATE OF DEATH: Month June day 27,  
 year 1944 hour 7 minute 10 P. M.  
 21. I hereby certify that I attended the deceased from June 6, 19 44 to June 27, 19 44;  
 that I last saw him alive on June 27, 19 44;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia  
 Duration Terminal

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

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy Same as above

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) (e) Means of injury

23. Signature Alva Massey (M. D. or other) \_\_\_\_\_  
 Address 3601 White Date signed 6/28/44

**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

Licensed Embalmer No. *2698*

P. O. Address. *2769 Chouteau*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July  
5923  
Registrar's No. \_\_\_\_\_

Registration District No. 318

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

3. (a) PRINT FULL NAME Daisy Williams

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

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

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

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

8. AGE: Years 42 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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

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

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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

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

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

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

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

19. (a) JUL 12 1944 (Date received local registrar's certificate) J. F. Bueck (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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 \_\_\_\_\_

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

PHYSICIAN  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

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