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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

8787

FILED OCT 23 1944

Registration District No. 818

Primary Registration District No. 1003

Registrar's No.

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

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 2 months 7 days
In this community Life
(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. 821 N. 21st St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Clara Williams

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

5. Color or race Female C 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive 12 years

7. Birth date of deceased H 12 1914
(Month) (Day) (Year)

8. AGE: Years 30 Months 6 Days 1 If less than one day hr. min.

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

10. Usual occupation MAID
11. Industry or business George Williams

12. Name UNKNOWN

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

14. Maiden name " " 9

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

16. (a) Informant Alberta Reid

(b) Address 4106 3/4 Evans

17. (a) BURIAL (b) Date thereof 10-17-44
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. F. Bulech

(b) Address 318 3/4 Washington

19. (a) OCT 16 1944 (b) J. F. Bulech
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 13,
year 1944 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from August
6, 1944 to October 13, 1944
that I last saw him alive on October 13, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Uterus with metastasis Duration Unk.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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?

While at work? (Specify type of place) (e) Means of injury

23. Signature A. M. Mitchell (M. D. or other)

Address 26017 Whittier Date signed 10/14/44

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

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. C. Claude Gordon

Licensed Embalmer No. *3459*

P. O. Address. *415 76 Aldine*

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.