

Registration District No. 318
FILED JAN 31 1945

Primary Registration District No. _____

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

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days 0
(Specify whether _____)

3. (a) PRINT FULL NAME Baby Williams
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Negro
6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 11 20 44
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>3</u>	hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
12. Name Tommie Williams
13. Birthplace Wakes Ct. Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Adelle Carter
15. Birthplace Macon Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Mary T. Duvall
(b) Address 2601 N. Whittier St.

17. (a) _____ (b) Date thereof JAN 25 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director J. B. Hudson
(b) Address City Health Dept

19. (a) JAN 24 1945 (Date received local registrar) J. Z. Brediek (Registrar's signature)

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. 2324 Cass Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 23
year 44 hour 5 minute 00 a. M.
21. I hereby certify that I attended the deceased from 11 - 20
1944, to 11 - 23 19 44
that I last saw her alive on 11 - 23 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity;
Bronchial Pneumonia

Due to Unknown

Due to Unknown

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 William D. Habler (M. D. or other)
Address 2601 N. Whittier St. Date signed 11-22-45

Duration _____
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.....

Licensed Embalmer No.....

P. O. Address.....

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.