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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11930

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 3974

1. PLACE OF DEATH:

(a) County ST, Louis, MO
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Isolation Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution March 28/45 to April 3/45 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 17
(c) City or town ST, Louis MO 013 (If outside city or town limits, write "RURAL")
(d) Street No. 5800 Arsenal ST (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Corine Williams
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased ? (Month) ? (Day) 1888 (Year)
8. AGE: Years abt-57 Months ? Days — If less than one day hr. min.
9. Birthplace ? (City, town, or county) (State or foreign country)
10. Usual occupation Dressmaker
11. Industry or business
FATHER 12. Name ?
13. Birthplace ? (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name ?
15. Birthplace ? (City, town, or county) (State or foreign country)
16. (a) Informant Viola Becktame
(b) Address 5600 Arsenal ST
17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 4-11-45 (Month) (Day) (Year)
(c) Place: burial or cremation St Louis
18. (a) Signature of funeral director W. Kuhlen
(b) Address 3500 Kutzer St
19. (a) MAY 4 1945 (Date received local registrar) (b) J. F. Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3 year 1945 hour 7 minute 45 A M.
21. I hereby certify that I attended the deceased from 3/28, 1945 to 4/3 45; that I last saw her alive on 4/3/, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition

Due to

Due to

Other conditions Senility
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature R W Maxwell (M. D. or other)
Address 5600 Arsenal St Date signed 4-5-45

(Licensed Embalmer's Statement on Reverse Side)

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.