

FILED MAY 3 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11935

State File No.

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3584**

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mo
In this community 1 year
years, months or days (Specify whether)

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

4. Sex etc 3. Color or race Negro 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife etc 6. (c) Age of husband or wife if alive 18 years (Month) (Day) (Year)

8. AGE: Years 53 Months 2 Days 3 If less than one day by min.

9. Birthplace Hot Springs Arkansas (City, town, or county) (State or foreign country)

10. Usual occupation Domestic work

11. Industry or business Private Res

12. Name Swansley King
13. Birthplace Hot Springs Ark (City, town, or county) (State or foreign country)
14. Maiden name Rose Gay
15. Birthplace Arkansas (City, town, or county) (State or foreign country)

16. (a) Informant Samuel Williams
(b) Address 1818 N Whittier St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/25/45 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem

18. (a) Signature of funeral director Boyle Bros
(b) Address 3704 McKinley Ave

19. (a) APR 23 1945 (Date received local registrar) J. F. Budeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo County 000
(c) City or town St Louis
(d) Street No. 1818 N Whittier
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 19 year 1945 hour 10 minute 30 P.
21. I hereby certify that I attended the deceased from February 19, 1945, to April 21, 1945, that I last saw her alive on April 21, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death UREMIA Duration 10 DA

Due to URTEROPELVIC STRICTURE

Due to UTERUS, ADENOCARCINOMA OF 2 YRS

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations H8
Of autopsy UTERUS, ADENOCARCINOMA OF, WITH METASTASIS TO BLADDER, LIVER, BRAIN ETC

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 J. F. Budeck (M. D. or other) 0
Address Barnes Hospital Date signed 4-22-45

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 *James A. Johnson*

Licensed Embalmer No. *3522*

P. O. Address *3506 Franklin 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.