

FILED JUN 4 1945

318

Primary Registration District No.

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

79

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Missouri Pacific Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days  
(Specify whether)

In this community 35 years  
years, months or days

3. (a) PRINT FULL NAME WILLIATT WILLIATTS.

3. (b) If veteran, name war

3. (c) Social Security No. 499-015520

4. Sex male 2      5. Color or race Col

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Bessie Williams

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Feb 15 1886  
(Month) (Day) (Year)

8. AGE:      Years      Months      Days      If less than one day

59      3      24      hr.      min.

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

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Mrs. Bessie Williams

(b) Address 718 Marshall Ave

17. (a) Burial (b) Date thereof 5-25-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director John H. Hembick

(b) Address 408 So. Filmore Ave. Webster, Mo

19. (a) MAY 23 1945 J. J. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Valley Park 16  
(If outside city or town limits, write "RURAL")

(d) Street No. 718 Marshall Ave  
(If rural, give location)

(e) Citizen of foreign country? USA 1 (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 19 1945  
year 1945 hour 5 minute 25 P.M.

21. I hereby certify that I attended the deceased from 5/15/45 19...  
to 5/19/45 19...;

that I last saw him alive on 5/19/45 19...  
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis

Due to Ruptured appendix

Due to 12/1

Other conditions Partial obstruction  
(Include present within 3 months of death)

Major findings: Ruptured appendix

Of autopsy

Duration

PHYSICIAN

Underline cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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 J. Schlenker (M. D. or other)

Address 1170 P.O. Hoop Date signed 5/19/45

NOV 28 1945

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.

*myself*

Signed.....  
*W. H. ...*

Licensed Embalmer No. *22766*

P. O. Address *3512 Thomas St. ...*

**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.**