

S. No. 2
M-5-43
r. 5-17-39
P I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19350

FILED JUN 19 1945

State File No. _____
Registrar's No. 5098

Registration District No. 818

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(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:
St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 days
(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. 2857 Victor
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CORRINNA WILLIAMS

3. (b) If veteran, name war nil 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widow

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

7. Birth date of deceased June 28, 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>11</u>	<u>11</u>	hr. _____ min. _____

9. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Cancel Waters

13. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. J. Williams

(b) Address 2857 Victor

17. (a) Burial (b) Date thereof June 11, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Piggott, Ark

18. (a) Signature of funeral director JOS. A. HOWARD

(b) Address 1619 So. Grand Blvd.

19. (a) JUN 9 1945 J. F. Bredeck
(Date registered) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8th
year 1945 hour 1:30 minute A. M.

21. I hereby certify that I attended the deceased from 5/16/45
_____ 19____, to 6/8/45 19____;
that I last saw her alive on 6/8/45 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the Esophagus, squamous cell type

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) here 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 Arion Heider (M. D. or other) _____
Address 1515 Lafayette 6/8/45

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

MOTHER FATHER

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..... *John Oguroshi*
Licensed Embalmer No. *3398*

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.