

Registration District No. **318** Primary Registration District No. _____

1. PLACE OF DEATH: **St Louis**
 (a) County _____
 (b) City or town _____
 (c) Name of hospital or institution: **Romer Phillips Hos, (Enroute)**
 (If outside city or town limits, write "RURAL" and name of township)
 (d) Length of stay: In hospital or institution **10 Hrs.**
 (If not in hospital or institution, write street number or location)
 In this community **2 years.** **3** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **St Louis** **11 21**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **2326 Division St.**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Nancy Smith**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color of race **Col,**
 6. (a) Single, widowed, married, divorced **Widow**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Nov. 15 1903**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 1 - hr. min.

9. Birthplace **Washington Co, Miss. 1**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **Domestic**

MOTHER FATHER

11. Industry or business _____
 12. Name **Mose Williams**
 13. Birthplace **Va. 1**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Joseph Berry**
 (b) Address **406 a Montrose St**

17. (a) **Burial** (b) Date thereof **12/20/45**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Washington Park Cem**

18. (a) Signature of funeral director **Ellis Fun, Home**
 (b) Address **2320 Stoddard St**

19. (a) **DEC 19 1945** (b) **J. F. Budeck**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Dec,** **15th,**
 year **1945** hour **5/15** minute **A. M.**
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary Thrombosis
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 5 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?

While at work? _____ (Specify type of place)
 (a) Means of injury _____
 23. Signature **Thomas F. Callahan** (M.D. or other) **12-17-45**
 Address **Carroll** Date signed _____

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 L. B. Boyk

....., Registered Apprentice No. 57

working under my personal supervision.

Signed L. B. Boyk

Licensed Embalmer No. 2946

P. O. Address St. Louis

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.