

No. 2
-5-43
-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11816

State File No. _____
Registrar's No. **2338**

FILED APR 5 1946
Registration District No. _____

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:
815 N. 21st St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
5 Yrs. (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **815 N. 21st. St.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Hattie Williams**
3. (b) If veteran, name war _____
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **8**
year **1946** hour **9** minute **05** P. M.
21. I hereby certify that I attended the deceased from **October 10th, 1945** to **March 8, 1946**
that I last saw her alive on **March 8, 1946**
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **Negro**
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: **Mar. 1 1871**
(Month) (Day) (Year)
8. AGE: Years **75** Months **0** Days **7** If less than one day
_____ hr. _____ min.
9. Birthplace: **Ark. 1**
(City, town, or county) (State or foreign country)
10. Usual occupation **Unemployed**

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

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER {
16. (a) Informant **Lee Harris**
(b) Address **2133 A. Cole St.**
17. (a) **Burial** (b) Date thereof **Mar. 14-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Greenwood Dement and Son**
18. (a) Signature of funeral director **2631 Cole St**
(b) Address _____
19. (a) **MAR 11 1946** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

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) Means of injury _____
Signature **Plan D. Carter** (M. D. or other) **M.D.**
Address **2425 Biddle** Date signed **3/9/46**

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

10723

2844 (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, ~~and~~ by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *W. Claude Gordon*

Licensed Embalmer No..... *3489*

P. O. Address..... *457 1/2 Aldine*

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.