V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

28061

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29223

FILED SEP 13 1946

1003

Registration District No. ____ Primary Registration District No. ____ Registrar's No. 7625

1. PLACE OF DEATH:

(a) County ____

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

(c) Name of hospital or institution: 2942 Bell Ave. 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill. (b) County 999

(c) City or town E. St. Louis NR 11
(If outside city or town limits, write "RURAL")

(d) Street No. 3915 Piggott Ave. 2
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 2

If yes, name country ____

3. (a) PRINT FULL NAME EMILY WILLIS

3. (b) If veteran, name war -- 3. (c) Social Security No. --

4. Sex Female 3 | 5. Color or race C | 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Unavailable (Month) 1876 (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
✓ Abt 70			hr. ____ min.

9. Birthplace Xenia (City, town, or county) Ohio (State or foreign country)

10. Usual occupation Retired school teacher.

11. Industry or business E. St. Louis Ill.

FATHER 12. Name David Willis

13. Birthplace Unavailable (City, town, or county) Va. (State or foreign country)

MOTHER 14. Maiden name Josephine Williams

15. Birthplace Xenia (City, town, or county) Ohio (State or foreign country)

16. (a) Informant Miss Ruth Scott

(b) Address 2942 Bell Ave.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-4-46 (Month) (Day) (Year)

(c) Place: burial or cremation Xenia, Ohio.

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Ave.

19. (a) SEP 4 1946 (Date received local registrar) (b) J. L. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 29 year 1946 hour 4 minute P M.

21. I hereby certify that I attended the deceased from August 29 1946 to August 29 1946; that I last saw her alive on 8-29 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Occlusion	12 hrs
Due to: Arteriosclerosis	Unknown
Due to:	
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.

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)

While at work? ____ (e) Means of injury 0

23. Signature H. E. Smith (M. D. or other)

Address 11 N. Jefferson Ave. Date signed 9-3-46

(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, or by

Chas. J. Gates Registered Apprentice No.,

working under my personal supervision.

Signed Chas J Gates

Licensed Embalmer No. 1825

P. O. Address 4107 Finney 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.