

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

State File No. **35729**
Registrar's No. **8722**

FILED **SEP 21 1946**

Registration District No. **318** Primary Registration District No. **1003**

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:
2621 DICKSON ST.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (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. **2621 DICKSON ST.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

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

4. Sex **FEMALE** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Oct. 15 1882**
(Month) (Day) (Year)

8. AGE: Years **63** Months **11** Days **20** If less than one day _____ hr. _____ min.

9. Birthplace **TUNA MISS**
(City, town, or county) (State or foreign country)

10. Usual occupation **House work**

11. Industry or business _____
12. Name **UNK.**
13. Birthplace **UNK.**
(City, town, or county) (State or foreign country)
14. Maiden name **MARY English**
15. Birthplace **UNK MISS**
(City, town, or county) (State or foreign country)

16. (a) Informant **Estella Bolden**
(b) Address **2621 DICKSON AVE**

17. (a) **BURIAL** (b) Date thereof **Oct. 11, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Pk.**

18. (a) Signature of funeral director **English Und. Co.**
(b) Address **2931 LUTHERS AVE**

19. (a) **OCT 10 1946** (b) **J. F. Bredeek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **7** year **1946** hour **7** minute **00 a.m.**
21. I hereby certify that I attended the deceased from **6-13-46** to **10-7-46** that I last saw her alive on **10-13-46** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **Hypertension**

Other conditions (Include pregnancy within 3 months of death) **85a**

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? **0**

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature **Oliver E. Kane** (M. D. or other) **MD**
Address **1706 Walnut** Date signed **10/10/46**

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

MOTHER FATHER

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 *Buckson English*.....

Licensed Embalmer No. *4208*.....

P. O. Address. *2931 Lucas, Ar*.....

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.