

S. No. 2
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5-17-39
X47070

REGISTRATION DISTRICT NO. 317
BUREAU OF HEALTH
FILED JAN 16 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3364
State File No. 3653
Registrar's No. 3653

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

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: St. Louis
(c) Name of hospital or institution: St. Mary's Hospital
(d) Length of stay: 2 months
In this community: 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jefferson
(c) City or town: Crystal City
(d) Street No.: 400 Jefferson
(e) Citizen of foreign country?

3. (a) PRINT FULL NAME: Thomas L. Williams
3. (b) If veteran, name war:
3. (c) Social Security No.:

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 2 year 1947 hour 4 minute 15 P. M.
21. I hereby certify that I attended the deceased from Nov 1, 1946, to Jan 2, 1947
that I last saw him alive on Jan 2, 1947
and that death occurred on the date and hour stated above.

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (c) Age of husband or wife if alive: years

Immediate cause of death: Bulbar Paralysis
Due to: encephalomyelitis
Due to: tuberculous
Other conditions: g D
Major findings: Fluor X-ray
Of operations: no
Of autopsy: no

7. Birth date of deceased: May 10, 1940
8. AGE: Years 6 Months 7 Days 22
If less than one day: hr. min.

9. Birthplace: Crystal City Missouri
10. Usual occupation: Child
11. Industry or business: Child

MOTHER FATHER
12. Name: Clarence Williams
13. Birthplace: Piedmont Missouri
14. Maiden name: Hortense Voelker
15. Birthplace: St. Mary's, Missouri

16. (a) Informant: Clarence Williams
(b) Address: Crystal City, Mo.
17. (a) Burial (b) Date thereof: January, 1947
(c) Place: burial or cremation: Crystal City, Mo.
18. (a) Signature of funeral director: John R. Holitte
(b) Address: Crystal City, Mo.

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

19. (a) 1-4-47 (b) W. H. Allen
(Date received local registrar) (Registrar's signature)

23. Signature: W. H. Allen (M. D. or other) MD
Address: Crystal City, Mo. Date signed: 1/3/47

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

Geoffrey R. Palitte

Licensed Embalmer No. *3481*

P. O. Address. *Crystal City, Md*

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.