

No. 2
-12-45
5-17-39
I X47070

FILED APR 14 1947
Registration District No. **318**

Primary Registration District No. **1003**

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

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:
820 HICKORY ST. 1
(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. 820 HICKORY ST.
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME OLIVER WILLIAMS

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

4. Sex MALE 5. Color or race W. 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 JANUARY 27 1904
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3
 year 1947 hour 9:30 minute A. M.

21. I hereby certify that I attended the deceased from March 25
1947 to April 2, 1947
 that I last saw him alive on April 2, 1947,
 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>43</u>	<u>2</u>	<u>7</u>	hr. min.

9. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

10. Usual occupation NIL

Immediate cause of death Tuberculosis

Due to Lues

Due to Malnutrition

Other conditions Malnutrition
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business.....

12. Name GEORGE WILLIAMS

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

14. Maiden name LENOR KEMPER

15. Birthplace KANSAS MO.
(City, town, or county) (State or foreign country)

16. (a) Informant Dolly Williams
 (b) Address 820 Hickory

17. (a) BURIAL (b) Date thereof APRIL 4-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director E. J. Schurer
 (b) Address 3125 Lafayette av

19. (a) APR 4 1947 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Of operations.....
 Of autopsy.....

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 6

23. Signature Ab Stergen, M.D.
 Address 1101 Park Date signed.....

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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 James B. Vollmer
Licensed Embalmer No. 4014
P. O. Address 3125 Lafayette Ave 4

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.