

FILED MAY 1947
Registration District No. 18187

Primary Registration District No. 1003

Registrar's No. 4256

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: City Hospital
 (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)

3. (a) PRINT FULL NAME Charles Williamson

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, married
 6. (b) Name of husband or wife..... Stella Williamson 6. (c) Age of husband or wife if alive..... 71 years
 7. Birth date of deceased..... 7 (Month) 1 (Day) 1874 (Year)

8. AGE:	Years	Months	Days	If less than one day
	72	9	24 hr. min.

9. Birthplace..... Butler Illinois
(City, town, or county) (State or foreign country)10. Usual occupation Grocer and Meat Market11. Industry or business Self12. Name Jacob Williamson13. Birthplace..... unknown a
(City, town, or county) (State or foreign country)14. Maiden name unknown15. Birthplace..... unknown 9
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. Stella Williamson(b) Address 4900 Claxton Ave.17. (a) burial (b) Date thereof 4/28/47
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Zion Cemetery18. (a) Signature of funeral director Drehmann-Harral(b) Address 1905 Union Blvd.19. (a) APR 25 1947 (b) J. F. Prudek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
 (c) City or town..... St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4900 Claxton Ave.
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25
year..... 1947 hour..... 4:05 minute..... A. M.

21. I hereby certify that I attended the deceased from.....
, 19....., to....., 19.....
 that I last saw h..... alive on....., 19.....
 and that death occurred on the date and hour stated above.

Immediate cause of death.....

Lobar Pneumonia
 Due to.....

Due to.....

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

23. Signature Patrick C. Taylor (M. D. or other.....)Address 1300 Clark Date signed 4/25/47

PHYSICIAN

Underline
 the cause of
 which death
 should be
 charged sta-
 tistically.

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.....

Warren P Carver

Licensed Embalmer No.....

3534

P. O. Address.....

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.