S. No. 2
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29674

FILED SEP 2 1947

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 7872

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: 4142 Kennerly Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether in this community) Abt. 35 Years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 00

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

(d) Street No.: 4142 Kennerly Avenue
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: Martha Fuller Williams

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: Female

5. Color or race: Negro

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Halliday Williams

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: March (Month) 20 (Day) 1900 (Year)

8. AGE: Years 47 | Months 4 | Days 24 | If less than one day: hr. min.

9. Birthplace: Clarksville, Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Unavailable
13. Birthplace: Unavailable
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Mattie Bronough
15. Birthplace: Clarksville, Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant: Alonzo Fuller
(b) Address: 4150 West Belle Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/20/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Washington Park Cem.

18. (a) Signature of funeral director: Chas. J. Gates
(b) Address: 4107 Finney Avenue

19. (a) AUG 19 1947 (Date received local registrar) (b) J. F. Bricek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 14 year 1947 hour 10 minute 33 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.

	Duration
Immediate cause of death: Coronary Thrombosis	
Due to: DHD	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause of 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

23. Signature: Thomas L. Callaway Cor (M. D. or other)
Address: 1300 Clark Avenue Date signed: 8-19-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

AUG 19 1947

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

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 ..... Thomas J. Gates ....., Registered Apprentice No. ..... working under my personal supervision.

Signed ..... [signature]

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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.