No. 2
1/47
5-17-39

#79592

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40344

FILED DEC 6 1947

Registration District No. 318

Primary Registration District No. 1005

Registrar's No. 10709

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri. (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 4 DAYS (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000

(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") 17

(d) Street No. 4430 S. GRAND Bl. (If rural, give location) 9

-15-

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

If yes, name country

3. (a) PRINT FULL NAME BESSIE WILLIAMSON

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife

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

7. Birth date of deceased SEPT 9, 1887 (Month) (Day) (Year)

8. AGE: Years 60 Months 2 Days 10 If less than one day hr. min.

9. Birthplace NEWPORT (City, town, or county) ARKANSAS (State or foreign country)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name JAMES BROOKS
13. Birthplace ARKANSAS (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mc ENERY
15. Birthplace ARKANSAS (City, town, or county) (State or foreign country)

16. (a) Informant WADE WILLIAMSON

(b) Address P.O. 272 SPRINGFIELD, ILL.

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof NOV 21, 1947 (Month) (Day) (Year)

(c) Place: burial or cremation SAN ANTONIO TEXAS

18. (a) Signature of funeral director Wm Schumacher

(b) Address 3013 Miramar St

19. (a) NOV 21 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19th year 1947 hour 8 minute 15 A M.

21. I hereby certify that I attended the deceased from 11/16/47, 19, to Nov. 19th 1947 that I last saw her alive on Nov. 19th 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Ca of Uterus — far advanced

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

48

Duration

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) No

(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 Ed Remon M.D. (M.D. or other)

Address 1515 Lafayette Date signed 11/19/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

S

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 Francis Williamson

Licensed Embalmer No. 3565

P. O. Address St. Louis Mo.

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.

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10709

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:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Bessie Williamson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 9 (Month) (Day) (Year)

8. AGE: Years 60 Months 2 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Ark. (State or foreign country)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

DEC 11 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day Sept 9 year 1947 hour minute 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 — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

40344