No. 2
12-45
17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3604

FILED JAN 10 1948

Registration District No. 3207 Primary Registration District No. 6076 Registrar's No. 17

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

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town LEMAY MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 6 SUMMITT AVE. 1
(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 Mo. (b) County St Louis Co
(c) City or town LEMAY 0
(If outside city or town limits, write "RURAL")
(d) Street No. 6 SUMMITT 0
(If rural, give location) 0
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME GRACE WATERS WILLIAMS
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex FEMALE 1
5. Color or race WHITE
6. (a) Single, widowed, married, divorced DIVORCED
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased JANUARY (Month) 6 (Day) 1877 (Year)

8. AGE: Years	Months	Days	If less than one day
70	11	26	..... hr. ..... min.

9. Birthplace ST. LOUIS MO (City, town, or county) (State or foreign country)
10. Usual occupation HOUSE WIFE
11. Industry or business .....
FATHER 12. Name THOMAS DONOVAN
13. Birthplace MISSISSIPPI (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name MARY ROBERTS
15. Birthplace NEW YORK 1 (City, town, or county) (State or foreign country)
16. (a) Informant L. B. WATERS
(b) Address 4252 NEOSHO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 5 1948 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEM.
18. (a) Signature of funeral director Thomas Kute's Son
(b) Address 2906 GRAVOIS
19. (a) 1-5-48 (Date received local registrar) (b) Paulina Stark, M.D. (Registrar's signature) Pro

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 2 year 1948 hour 6 minute 40 P.M.
21. I hereby certify that I attended the deceased from 12/12 3 19 46, to 1/2 19 48, that I last saw h. alive on 12/22 19 47, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
CEREBRAL ACCIDENT	1 HR.
Due to HYPERTENSION 05	1 YR. +
ARTERIOS CLEROSIS	1 YR +
Due to PAROXYSMAL TACHYCARDIA	9 MOS
CARDIAC ASTHMA	9 MOS

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 0
23. Signature Harry Ogden (M. D. or other) MD
Address 634 N Grand Date signed 1/3/48

(Licensed Embalmer's Statement on Reverse Side)

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 Leo J. Budde

Licensed Embalmer No. 3289

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.