

No. 2
5-42
17-39
X32873

Registration District No.

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. LOUIS MATERNITY 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 INFANT MALE WILLIAMS

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.....

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

7. Birth date of deceased AUGUST 11 (Month) (Day) (Year) 48

8. AGE: Years Months Days If less than one day
46 hr. 45 min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name ELMER LEE WILLIAMS

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

14. Maiden name ANNA BELL PLATT

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

16. (a) Informant ST. LOUIS MATERNITY HOSPITAL

(b) Address 630 SO. KING HIGHWAY

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 8-13-48 (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd.

19. (a) AUG 13 1948 (Date received local registrar) (b) J. F. Bredet (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. 5240 THEODOSIA
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 12
year 48 hour 10:10 minute A M.

21. I hereby certify that I attended the deceased from AUGUST 11
19 48 to AUGUST 12 19 48
that I last saw him alive on AUGUST 12 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Intra cranial hemorrhage

Due to parturition

Due to Heart

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?

While at work? (Specify type of place) (e) Means of injury.....

23. Signature Carl T. Woolley, M.D. (M. D. or other)

Address 630 S. Kings Highway Date signed 8-12-48

Duration 16 hrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE 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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Warren A. 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.