

No. 10-47
1-17-39
PI 3906

FILED OCT 23 1948-318
Registration District No. 318

Primary Registration District No. 1005

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

1. PLACE OF DEATH:
(a) County ST. LOUIS
(b) City or town ST. LOUIS
(c) Name of hospital or institution HOMER G. PHILLIPS
(d) Length of stay: In hospital or institution (Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County MO.
(c) City or town ST. LOUIS
(d) Street No. 2802 SPRUCE ST 5
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME RAONIS WILLIAMS
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month OCT day 15 year 1948 hour 10 minute 15 M.
21. I hereby certify that I attended the deceased from that I last saw him alive on and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color of race COL 6. (a) Single, widowed, married, divorced, MARRIED
6. (b) Name of husband or wife FRANCIS WILLIAMS 6. (c) Age of husband or wife if alive 30 years
7. Birth date of deceased MAR 16 1917 (Month) (Day) (Year)

Immediate cause of death Localized Peritonitis, Oedema of Brain; as a result of ruptured Appendix, following Appendectomy, at Homer G. Phillips Hospital, on Oct. 14, 1948, about 5:15 PM

8. AGE: Years 31 Months 6 Days 29 If less than one day hr. min.

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.

9. Birthplace MARSTON MO. U (City, town, or county) (State or foreign country)
10. Usual occupation SHIPPING CLERK.
11. Industry or business
12. Name BEN WILLIAMS
13. Birthplace MO.
14. Maiden name MIANIE WESTBROOK
15. Birthplace MO. U (City, town, or county) (State or foreign country)

16. (a) Informant FRANCIS WILLIAMS (b) Address 2802 SPRUCE ST
17. (a) BURIAL (b) Date thereof OCT 20/48 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director F. A. GREEN (b) Address 4214 DELMAR
19. (a) OCT 18 1948 (Date received local registrar) (b) J. B. Laster (Registrar's signature)

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) Means of injury 3.
23. Signature Gabriel E. Taylor (M.D. Physician) Address 1300 Clear Date signed 10-18-48

Handwritten mark

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 *L. A. Green*

Licensed Embalmer No. *2963*

P. O. Address *4214 Delmar*

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.