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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 38797
Registrar's No. 10609

Registration District No. 318

Primary Registration District No. 1003

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

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:
4915 Delmar Blvd.
(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 DR. GILBERT R. 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 Married /

6. (b) Name of husband or wife Bertha Williams
6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 74 - - hr. min.

9. Birthplace Olney Illinois /
(City, town, or county) (State or foreign country)

10. Usual occupation Dentist

11. Industry or business Unknown

MOTHER FATHER

12. Name Unknown 9

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

14. Maiden name Unknown (City, town, or county) (State or foreign country) 9

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

16. (a) Informant Bertha Williams

(b) Address 1210 N. Kingshighway

17. (a) Burial (b) Date thereof 12-8-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cem.

18. (a) Signature of funeral director Herman Rindskopf, Inc.
(b) Address 5216 Delmar Blvd.

19. (a) DEC 7 1948 (b) J. B. [Signature]
(Date received local registrar) (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. 1210 N. Kingshighway
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6
year 1948 hour 10:00 minute A.M.

21. I hereby certify that I attended the deceased from July 1948 to Dec 5 1948
that I last saw him alive on Dec 5 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease
Duration 1 year

Due to Arteriosclerosis 5 yrs.

Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy
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?

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

23. Signature Martin W. Davis (M. D. or other)
Address 539 N. Grand Date signed 12/7/48

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 _____

John Ketter

Licensed Embalmer No. 3880

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.