

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

15832

**1. PLACE OF DEATH**

County.....  
Township.....  
City St. Louis Mo (No. 4305)

Registration District No. 791  
Primary Registration District No. 1003

File No.....  
Registered No. 3650  
St. .... Ward)

**2. FULL NAME** William O. Pilcher

(a) Residence. No. .... St. 10 Ward.

(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) <u>Rena E. Pilcher</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 5<sup>th</sup> 1868</u>		
7. AGE	YEARS <u>59</u>	MONTHS <u>10</u>
	DAYS <u>10</u>	
	IF LESS than 1 day, ..... hrs. or ..... min.	
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Automobile</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Mechanic</u>		
(c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) Brownstown  
(STATE OR COUNTRY) Ills

10. NAME OF FATHER Charles B. Pilcher

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Brownstown  
(STATE OR COUNTRY) Ills

12. MAIDEN NAME OF MOTHER Lydia Herkey

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....  
(STATE OR COUNTRY) Penn

14. INFORMANT Rena E. Pilcher  
(Address) 4305 Pleasant St

15. FILED 16 1927 REGISTRY Man G. Starroff

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 15 1927  
17.

I HEREBY CERTIFY, That I attended deceased from April 3, 1927, to April 15, 1927.  
That I last saw him alive on April 16, 1927, and that death occurred, on the date stated above, at 4:30 p.m.

18. THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Endocarditis and Chronic parenchymatous nephritis (duration) yrs. mos. da. 9

CONTRIBUTORY (SECONDARY) 129 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? No DATE OF.....  
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....  
(Signed) Arthur H. Fox, M. D.  
April 16 1927 (Address) 1901 Madison St.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Brownstown Ills DATE OF BURIAL April 17 1927

20. UNDERTAKER Math Hermann & Son 4103 Flourissant

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WITH WRAPPING TAPE—THIS IS A PERMANENT RECORD



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... (No. ....)

Registration District No. 799  
Primary Registration District No. 1003

File No. ....  
Registered No. 3650  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... St., ..... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... ds.  
(b) General nature of industry, business, or establishment in which employed (or employer) ..... (duration) ..... yrs. .... mos. .... ds.  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY)

14. INFORMANT ..... (Address)

15. FILED JUL - 9 1927 maub Starkeoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) APR 15 1927

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... that I last saw him ..... alive on ..... 19..... and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) .....

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D. , 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-13332