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.

B- 18512 MAY 7 1937

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

Do not use this space.

14206

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis, Missouri (No. City Hospital #1 St. ..... Ward)

File No. ..... Registered No. 3702

2. FULL NAME William Renaud

(a) Residence, No. 329 E. Courteis St., / Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)

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: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4/29/1888

7. AGE: 48 YEARS, 11 MONTHS, 4 DAYS. If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Lab.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. common

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

FATHER

13. NAME Charles Renaud

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada

MOTHER

15. MAIDEN NAME Mary Lamb

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?

17. INFORMANT (ADDRESS) M. Williams City Hospital #1

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Hope Cem. DATE 4-6 1937

19. UNDERTAKER (ADDRESS) Fendler Und Co 7420 Michigan ave.

20. FILED APR 6 1937 J F Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/2/37, 19

22. I HEREBY CERTIFY, That I attended deceased from 3/29/37, 19..., to 4/2/37, 19...

I last saw him alive on 4/2/37, 19... Death is said to have occurred on the date stated above, at 11:25 P

The principal cause of death and related causes of importance were as follows:

Bronchial Asthma — Date of onset

Other contributory causes of importance:

Degeneration H.D.

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19...

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) [signature] M. D.

(Address) City Hospital #1