

RECD APR 12 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS 791  
CERTIFICATE OF DEATH 1008

9124  
Do not use this space.

2889

1. PLACE OF DEATH

(a) County..... Registration District No.....  
(b) Township..... Primary Registration District No..... Registered No.....  
(c) City St. Louis (d) Street No. Homar Phillips Hospital St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred 23 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME <sup>530</sup> William Howard Gant

(a) Residence, No. 4316a Cook St. /// (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>C</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>Maude Gant</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 6, 1879</u>		
7. AGE	YEARS	MONTHS
	<u>59</u>	<u>8</u>
		DAYS
		<u>18</u>
		IF LESS than 1 day, .....hra. or .....min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Porter &amp; Cook</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	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) <u>Louisiana</u>		
FATHER	13. NAME <u>Henry Gant</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Louisiana</u>	
MOTHER	15. MAIDEN NAME <u>Sarah ?</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Louisiana</u>	
17. INFORMANT <u>Evelyn Hilliard</u> (ADDRESS) <u>2601 N Whittier</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Washington Park</u> DATE <u>March 28, 1939</u>		
19. FUNERAL DIRECTOR (NAME) <u>J. W. Bruce</u> (ADDRESS) <u>1003 N Harrison Ave</u>		
20. FUNERARY HOME <u>J. B. Budas</u> <u>Local Registrar</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 24, 1939

22. I HEREBY CERTIFY, That I attended deceased from February 20, 1939 to March 24, 1939

I last saw h. im alive on March 24, 1939. Death is said

to have occurred on the date stated above, at 4:45a.m.  
The principal cause of death and related causes of importance were as follows:

Hypertensiva heart disease

Date of onset  
2/20/39

Other contributory causes of importance:  
Chronic nephritis

Name of operation clinical Date of.....  
What test confirmed diagnosis?..... Was there an autopsy? no

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) H. J. Lyman, M. D.  
(Address) 2601 N Whittier

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.

MAR 27 1939

**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~~.....

*William C. McDowell*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*William C. McDowell*

Licensed Embalmer No.....

*2114*

P. O. Address *3506 Franklin*

**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, above space should be left blank.**