

MAY 15 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3750

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 No. 14 Days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William Garrison 625

3. (b) If veteran, name war No. 3. (c) Social Security No. 274-16-7340

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Separated
 6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 29 1904
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
35 5 27 _____ hr. _____ min.

9. Birthplace New York City New York
(City, town, or county) (State or foreign country)

10. Usual occupation Newspaper Writer

11. Industry or business _____

MOTHER FATHER { 12. Name James Garrison
 { 13. Birthplace Milwaukee Wisconsin
(City, town, or county) (State or foreign country)
 { 14. Maiden name Gertrude Strain
 { 15. Birthplace Montgomery City Maryland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sara Strain

(b) Address New York City, New York

17. (a) Cremation (b) Date thereof 4-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) APR 26 1940
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State New York Borough of Manhattan
Queens & Bronx
 (c) City or town New York City NR
(If outside city or town limits, write "RURAL")
 (d) Street No. Hotel Wellington
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26, year 1940 hour 11:20 minute A. M.

21. I hereby certify that I attended the deceased from March 12, 1940, to April 26, 1940; that I last saw him alive on April 26, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to _____
Due to _____

Other conditions: NS
(Include pregnancy within 3 months of death)

Major findings: NS
 Of operations _____
 Of autopsy _____

PHYSICIAN
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 J. A. ... (M. D. or other) _____
Address 1515 Lafayette Date signed 4/26/40

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

No Embalmer

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 _____

Licensed Embalmer No. _____

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, above space should be left blank.