

FILED JUN 6 1940
784

Registration District No. _____

Primary Registration District No. 111

Registrar's No. 1041

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis Park Hgt
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(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 2 1/2

8. (a) PRINT FULL NAME William H. McFall

3. (b) If veteran, name war _____ 3. (c) Social Security No. 498-09-0622

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife hanora McFall 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Jan 5, 1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Salesman

11. Industry or business Newspaper

12. Name Wm McFall

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

14. Maiden name Julia Polmiller

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

16. (a) Informant Mrs John Grider

(b) Address 3806 Loughborough

17. (a) Burial (b) Date thereof 6-2-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parthage, Mo.

18. (a) Signature of funeral director Southern Ind Co

(b) Address 6327 Grand

19. (a) MAY 21 1940 (b) W H McFall
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3806 Loughborough
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month May day 30 year 1940 hour _____ minute 6 a.m.

21. I hereby certify that I attended the deceased from 5/7/40 to 5/30 1940 that I last saw him alive on 5/29 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic thrombosis

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Prostatic hypertrophy
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underlines 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?

701
While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature W H McFall (M. D. or other) _____
Address 312 Olive St Date signed 5/31/40

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

MOTHER FATHER

Dr Bernard
Arcade Bldg

137

12-2-30

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..... *Virgil L. Berryman*.....
Licensed Embalmer No. *4018*.....
P. O. Address..... *St. Louis Mo.*.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

CL 5894

State File No. 19561

Registrar's No. 1041

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Rich. Hts.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(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 William H. McFall

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

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

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

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (If outside city or town limits write "RURAL")

(d) Street No..... (If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May - day 30 - year 40 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19....., and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Prostatic Hypertrophy

Of operations.....

Of autopsy.....

Duration.....

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 L. N. Beards (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

[Handwritten signature]

