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State File No. **36818**
9091

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County **FILED DEC 11 1940**

(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:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **8 Days**
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **William Trammell**

3. (b) If veteran, name war **WORLD**

3. (c) Social Security No. _____

4. Sex **MALE**

5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **APRIL 19 - 1879**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
41	6	14	hr. _____ min. _____

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

10. Usual occupation **UNEMPLOYED**

11. Industry or business _____

MOTHER FATHER {

12. Name **JOSEPH TRAMMELL**

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

14. Maiden name **ILLINOIS**

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

16. (a) Informant **JOSEPH TRAMMELL**

(b) Address **MAUDEN MO**

17. (a) **BORIAN** (b) Date thereof **11-6-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MAUDEN MO**

18. (a) Signature of funeral director **V. H. CRUIS**

(b) Address **MAUDEN MO**

19. (a) **NOV 4 1940** (b) **J. B. [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County _____

(c) City or town **ST LOUIS**
(If outside city or town limits, write "RURAL")

(d) Street No. **5369 ST LOUIS Ave.**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **3**, year **1940** hour **5:40** minute **A.M.**

21. I hereby certify that I attended the deceased from **October 27**, 19**40**, to **November 3**, 19**40**
that I last saw him alive on **November 3**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myelogenous leukemia**

Due to _____

Due to _____

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

Major findings: 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 _____

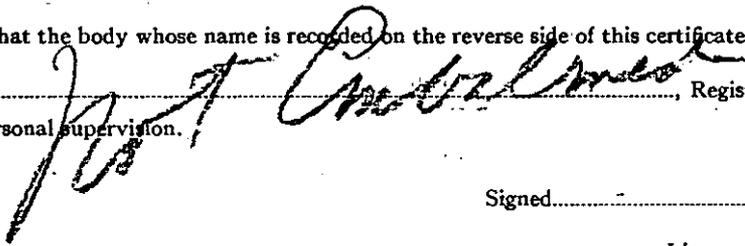
23. Signature **J. M. [Signature]** (M. D. or other) _____
Address **1515 Lafayette Ave.** Date signed **11/4/40**

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

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, fact should be so stated above.