

340  
S. No. 2  
M-5-42  
v. 5-17-39  
X32873

DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
FILED OCT 21 1942  
318

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31964

State File No. \_\_\_\_\_  
Registrar's No. 8399

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

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:  
St. Louis City Hospital 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Mo. 7 days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County 000  
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 69  
(d) Street No. 1909 Westmoreland  
(If rural, give location)  
(e) Citizen of foreign country? yes (Yes or No)  
If yes, name country \_\_\_\_\_ 0

3. (a) PRINT William Robert Gaddell  
FULL NAME  
3. (b) If veteran, name war no 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month October day 8,  
year 1942 hour 1:07 minute A. M.  
21. I hereby certify that I attended the deceased from September  
1, 1942, to October 8, 1942;  
that I last saw him alive on October 8, 1942;  
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced, MARRIED  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
7. Birth date of deceased June 11 1872  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Prostate cancer  
Duration \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>			hr. _____ min. _____

Due to Carcinoma of Prostate & widespread metastasis  
Due to 5/

9. Birthplace St. Peters Mo. 0  
(City, town, or county) (State or foreign country)  
10. Usual occupation Unemployed

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations Hypertrophy of Prostate  
Of autopsy Refused

11. Industry or business \_\_\_\_\_  
12. Name Jacob Gaddell  
13. Birthplace St. Peters Mo. 0  
(City, town, or county) (State or foreign country)  
14. Maiden name Mrs. Sully  
15. Birthplace Waterloo Ill. 1  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Emily Gaddell  
(b) Address 1909 Westmoreland  
17. (a) Burial (b) Date thereof 10-10-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

18. (a) Signature of funeral director Central Mort Co  
(b) Address 1841 Cass Ave  
19. (a) OCT 9 1942 (b) J. F. Berbeck  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature W. E. Mad... (M. D. or other)  
Address 1515 Lafayette Avenue Date signed 10/8/42

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

MOTHER FATHER

8631

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 J. Sullivan  
Licensed Embalmer No. 1122  
P. O. Address City

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.