

Registration District No. **MAR 30 1943**

Primary Registration District No. **1003**

Registrar's No. **2726**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **ST LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **ST LOUIS CITY HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 mos. 10 days**
In this community **1 YEAR**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME: **WILLIAM LESLIE BANCROFT**

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

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **3**

6. (b) Name of husband or wife **Albert Bancroft, Dorothy Bancroft** 6. (c) Age of husband or wife in years **26**

7. Birth date of deceased: **OCT 20 1910**
(Month) (Day) (Year)

8. AGE: Years **32** Months **5** Days **1** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Carpenter**

11. Industry or business **M.P.A.**

12. Name **Albert Bancroft** 13. Birthplace **Kansas**
(City, town, or county) (State or foreign country)

14. Maiden name **In name unknown** 15. Birthplace **Grand Tower - Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Albert M. Bancroft**

(b) Address **Bellville Ill.**

17. (a) **Removed** (b) Date thereof **3/24/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Louis**

18. (a) Signature of funeral director **J. F. Brueck**

(b) Address **6011 Olive - Ill.**

19. (a) **MAR 22 1943** (b) **J. F. Brueck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **000**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL") **998**
(d) Street No. **1514 1/2 15th St.**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **21**
year **1943** hour **1:25** AM minute _____ M.

21. I hereby certify that I attended the deceased from **12-11-1942** to **3-21-43** 19____
that I last saw him alive on **3-20-43** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: **LOBAR PNEUMONIA** **3 days**
PURULENT MENINGITIS "
Due to **MARKED EMACIATION** **4 mos.**

Due to **SYPHILIS & PARESIS & CARDIOVASCULAR SYPHILIS** **YEARS**

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

Major findings: **309**
Of operations _____
Of autopsy **SAME AS ABOVE**

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 **Thomas A. Sweetman, M.D.**
Address **1515 Lafayette** Date signed **3-21-43**

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

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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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed

Ben H. Baldwin

Licensed Embalmer No.

2490

P. O. Address

St. Louis 2, 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, fact should be so stated above.