

FILED FEB 4 1944 18

State File No. _____

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **904**

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:
Desloge 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. 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. **3434 Utah**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

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

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Mary Daniell** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Sept. 20 1865**
(Month) (Day) (Year)

8. AGE: Years **78** Months **4** Days **7** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Retired**

11. Industry or business _____

MOTHER FATHER
12. Name **Unknown**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Florence Amend**
(b) Address **3434 Utah St.**

17. (a) **Burial** (b) Date thereof **Jan. 31, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hiram Cemetery**

18. (a) Signature of funeral director **Wacker-Heldrich**
(b) Address **3634 Gravois Ave.**

19. (a) **JAN 20** (b) **J. F. Breese**
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **27**
year **1944** hour **3** minute **30** P. M.

21. I hereby certify that I attended the deceased from **Dec 20**
_____, 19**43**, to **Jan 28**, 19**44**

that I last saw him alive on **Jan 27**
and that death occurred on the date and hour stated above.

Immediate cause of death
Arteriosclerosis, Heart Disease, Hypertension, Pneumonia

Due to **Senescent arteriosclerosis**

Due to _____

Other conditions: **93**
(Include pregnancy within 3 months of death)

Major findings: **Senile Prostate, Hypertension**
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 **[Signature]** (M. D. or other) **MD**
Address **634 N. Grand** Date signed **1/2/44**

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..... *Frank J. Gilland*.....

Licensed Embalmer No..... *2645*.....

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, fact should be so stated above.