

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 3871

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: Barnes Hospital, 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 36 hours
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 11

(c) City or town Lawrenceville
(If outside city or town limits, write "RURAL") ONR-

(d) Street No. none (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Wilbur William Gould

3. (b) If veteran, name war unknown

3. (c) Social Security No. 344-01-0097

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced unk

6. (b) Name of husband or wife unk

6. (c) Age of husband or wife if alive unk year

7. Birth date of deceased June 11 1906
(Month) (Day) (Year)

8. AGE: 38 years 10 months 19 days If less than one day
hr. min.

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

10. Usual occupation Communications Engineer

11. Industry or business Thouby-Carlson Co

12. Name W. W. Gould

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

14. Maiden name May Venus

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

16. (a) Informant Barnes Hospital

(b) Address S. t. Louis

17. (a) Removal (b) Date thereof 5-1-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawrenceville, Ill.

18. (a) Signature of funeral director C. R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.

19. (a) MAY 1 1945 (b) J. F. Brudeck
(Date received by) registrar (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1945 hour 11 minute 55 P.M.

21. I hereby certify that I attended the deceased from April 29
1945 to April 30, 1945

that I last saw him alive on April 30, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death anemia

Due to chronic lymphatic leukemia 3-4 year

Due to _____

Other conditions (include pregnancy within 3 months of death) 74

Major findings: Of operations _____

Of autopsy chronic lymphatic leukemia

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) (c) Means of injury _____

23. Signature F. R. Bradley (M. D. or other) ONR-
Address Barnes Hospital Date signed 5/1/45

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

06
17
9

MOTHER, FATHER

APR 3 1961

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

Bradford A. Miles

.....
Licensed Embalmer No. *2901*

P. O. Address *University City, 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.