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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 22 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31497

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2248

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Facility 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 66 days (Specify whether
In this community 48 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 006

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4236-A Fairfax 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME PACE, William A.

3. (b) If veteran, name war World I

3. (c) Social Security No. Unknown

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Laura Pace

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased February (Month) 10 (Day) 1890 (Year)

8. AGE: Years 55 Months 7 Days 4 If less than one day hr. min.

9. Birthplace Clarksville (City, town, or county) Tennessee (State or foreign country) 1

10. Usual occupation Laborer

11. Industry or business --

FATHER
12. Name Not available
13. Birthplace Not available (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Not available
15. Birthplace Not available (City, town, or county) 9 (State or foreign country)

16. (a) Informant Clinical Clerk, Vet. Adm. Fac.
(b) Address Jefferson Barracks, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-45 (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Ave.

19. (a) 9-20-45 (Date received local registrar) (b) E. D. McGovran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 14
year 1945 hour 12:15 minute P. M.

21. I hereby certify that I attended the deceased from July 10, 1945, to September 14, 1945;
that I last saw him alive on September 14, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CORONARY ARTERIOSCLEROTIC HEART DISEASE WITH MYOCARDIAL DAMAGE, VALVULAR DAMAGE (AORTIC & MITRAL)	
Due to WITH ANGINAL SYNDROME. 94a	Unknown
Contributory Cause.	
Due to PLEURISY WITH EFFUSION.	Unknown
Other conditions -- (Include pregnancy within 3 months of death)	

Major findings:
Of operations No operation.
Of autopsy No 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) No
(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?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature E. V. EDWARDS, LT. COL., (M. D. or other) M.C.
Clinical Director.
Address Vet. Adm. Fac., Jeff. Brks., Mo. Date signed 9/14/45

(Licensed Embalmer's Statement on Reverse Side)

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

Thomas J. Gates, Registered Apprentice No.

working under my personal supervision.

Signed Thomas Gates

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Ave.

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.