

FILED NOV 2 1945 STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9120

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 Children's 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)

3. (a) PRINT FULL NAME William Lee Treece

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased October 4 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
16da. hr. min.

9. Birthplace Springfield Mo.
(City, town or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business.....

12. Name Harold Treece
13. Birthplace Unknown Illinois
(City, town or county) (State or foreign country)
14. Maiden name Barbara Rose Biesenthan
15. Birthplace Illinois
(City, town or county) (State or foreign country)

16. (a) Informant Barbara Treece
(b) Address Springfield, Ill.

17. (a) Removal (b) Date thereof 10-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) OCT 22 1945 (b) J. F. Brebeck
(Date received local health officer's report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Sarason 999
(c) City or town Springfield 10
(If outside city or town limits, write "RURAL")
(d) Street No. R.R. # 6 N.R. 2
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 20
year 1945 hour 10 minute 35 A.M.

21. I hereby certify that I attended the deceased from 10-8, 1945, to 10-20, 1945,
that I last saw live alive on 10-20, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital esophageal atresia
Tracheo-esophageal fistula

Duration

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
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 R. J. Blatter (M. D. or other) C
Address on R. Keipinger Date signed.....

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

100
17
9

9120

9120

9120

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, *Albert S. Hoppe*

Licensed Embalmer No. *2971*

P. O. Address.....

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.