DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 9 1946

318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38375

Registration District No. 1003

Primary Registration District No.

Registrar's No. 9820

1. PLACE OF DEATH:

(a) County

(b) City or town ST. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Infirmary Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10-24-46 to 11-16-46 (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. 1809 Franklin Avenue
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME William Becker

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years about 53 | Months | Days | If less than one day hr. min.

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

10. Usual occupation Watchman

11. Industry or business

FATHER
12. Name William
13. Birthplace Bertha Mo.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Bertha
15. Birthplace MO.
(City, town, or county) (State or foreign country)

16. (a) Informant City Infirmary Records

(b) Address 5800 Arsenal Street

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-18-46 (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles Mo

18. (a) Signature of funeral director HACKMAN BAUR FUN. HOME

(b) Address St. Charles Mo.

19. (a) NOV 18 1946 (Date received local registrar) (b) J. F. Broderick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 16 year 1946 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from 10-24-46, 19, to 11-16-1946, 19; that I last saw him alive on November 16, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of Stomach	1946+
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Palmer Romaine Bowlich (M. D. or other)

Address 5800 Arsenal Street Date signed 11/16/46

(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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed: Lex Campbell

Licensed Embalmer No. 3880

P. O. Address St Louis M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Klee

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9820

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:

(If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME William Becker

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb (Month) (Day) (Year)

8. AGE: Years 87 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

DEC 12 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day Feb 16 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY 16

38375

SR-2700