

FILED JAN 27 1947

318

Registration District No. Primary Registration District No.

1003

Registrar's No.

448

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:
1015 FAIRMOUNT AVENUE
(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. 1015 FAIRMOUNT
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM FORREST

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 WIDOWED
 6. (b) Name of husband or wife ANNA FORREST 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased SEPT 15 1854
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
92 3 28 hr. _____ min. _____

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

10. Usual occupation RETIRED MILLWRIGHT

11. Industry or business RETIRED

12. Name JOHN FORREST

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

14. Maiden name MARGARET CROSS

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

16. (a) Informant Margaret Forrest

(b) Address 1015 FAIRMOUNT AV.

17. (a) BURIAL (b) Date thereof 1 16 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEM.

18. (a) Signature of funeral director J. M. Miller

(b) Address 5155 DELMAR BL.

19. (a) JAN 15 1947 (b) J. F. Bredack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 13TH
 year 1947 hour 6:15 minute _____ P.M.

21. I hereby certify that I attended the deceased from 9-27-1946 to 1-10-1947
 that I last saw him alive on 1-10-1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer under and disease
 Due to _____
 Due to _____

Other conditions Heart failure, fracture of
(Include pre-mortem within 3 months of death)
 Major findings: of operations

Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) Accident
 (b) Date of occurrence September 17, 1946
 (c) Where did injury occur? In yard at his home
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
See above

While at work? NO (Specify type of place) (c) Means of injury Fall

23. Signature Dr. T. B. Jones (M. D. or other) MD
 Address 654 W. 2nd St. Date signed 1/13/47

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

MOTHER FATHER

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 *H. G. Harris*

Licensed Embalmer No. *3384*

P. O. Address *H. Harris*

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.