

No. 2
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5-17-39
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THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3300
Registrar's No. 4

FILED JAN 17 1947
318

Registration District No. _____ Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
3208 Morganford Road
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 47 years
years, months or days

3. (a) PRINT FULL NAME Mr. William T. Witt

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male

5. Color white race _____

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

6. (b) Name of husband or wife Anna Mae Witt

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased February 7th, 1900
(Month) (Day) (Year)

8. AGE: Years 47 Months 10 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business Wagner Electric Co.

12. Name John Witt

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

14. Maiden name Anna E. McDonald

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

16. (a) Informant Mrs. Anna Mae Witt

(b) Address 3208 Morganford Road

17. (a) Burial (b) Date thereof 1-4-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cem.

18. (a) Signature of funeral director Hy. Leidner U. Co.

(b) Address 2223 St. Louis Ave.

19. (a) JAN 2 - 1947 (b) J. J. Brubaker
(Date received local registrar) (Registrar's signature)

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. 3208 Morganford Road
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 1st
year 1947 hour 11:55 PM minute _____ M.

21. I hereby certify that I attended the deceased from May 20, 1946 to January 1, 1947
that I last saw her alive on January 1, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cardiac failure

Due to chronic heart disease

Due to Renal heart disease

Other conditions None
(include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings:
Of operations None

Of autopsy None

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) (c) Means of injury _____

23. Signature Elmer P. [unclear] (M. D. or other) _____

Address 225 [unclear] Date signed 1-2-47

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

MOTHER FATHER

100
for order 321-8
Incorporation

JUN 29 1954

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..... *Ch. Mayfield*

Licensed Embalmer No. *3077*

P. O. Address *2223 St. Louis A*

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.