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17-39

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
FILED JUN 16 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19597

Registration District No. 317

Primary Registration District No. 3069

Registrar's No. 1102

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 6136 Waterman Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME William S. Bascom

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6th
year 1947 hour 1 minute 20 P. M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Regina Bascom

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased: June 10 1877
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6/3, 1947 to 6/6, 1947
that I last saw him alive on 6/6, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>11</u>	<u>26</u>	hr. min.

Due to Suprapubic prostatectomy

Due to 932

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

10. Usual occupation: Asst. Sales Manager

11. Industry or business: McKesson-Robbins Drug Co.

Other conditions: Arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Major findings: Benign prostatic hypertrophy

Of operations: _____

Of autopsies: _____

12. Name: William S. Bascom

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

14. Maiden name: Jane Devaney

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

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 true of place)

While at work? _____ (c) Means of injury U

Signature W. F. Melick (M. D. _____)
Address 614 Mo. Theater Bldg Date signed 6/6/47

16. (a) Informant: Mrs. Regina Bascom

(b) Address: 6136 Waterman Ave

17. (a) Burial (b) Date thereof: 6-9-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Calvary Cemetery

18. (a) Signature of funeral director: Arthur J. Donnelly

(b) Address: 3840 Lindell Blvd

19. (a) 6-9-47 (b) Beula J. Shapley
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

JUN 18 1947

JUN 30 1947

Mr. Theodor Berg
No. 1111111111

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 Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3840 Linden

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.