

No. 300  
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FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics  
FILED MAR 11 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6630  
Registrar's No. 2074

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:  
(a) County St. Louis Mo.  
(b) City or town St. Louis Mo.  
(c) Name of hospital or institution: 709 S. Broadway  
(d) Length of stay: \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County St. Louis  
(c) City or town St. Louis  
(d) Street No. 709 S. Broadway  
(e) Citizen of foreign country? \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Wm. Larson  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. \_\_\_\_\_  
4. Sex Male 5. Color White  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
(b) Name of husband or wife \_\_\_\_\_  
(c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Jan 1868  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb day 7  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: 85 years \_\_\_\_\_ months \_\_\_\_\_ days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

Immediate cause of death Coronary Atherosclerosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER

11. Industry or business retailer  
12. Name Wm. Larson  
13. Birthplace Missouri  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_  
16. (a) Informant Thos. G. Colquhoun  
(b) Address 300 Clark St.

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? \_\_\_\_\_

17. (a) Anatomical Board Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(b) Address \_\_\_\_\_  
(c) Place: burial or cremation Anatomical Board FEB 29 1948  
Rowland Mortuary Service  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 4104 Manchester Ave.  
19. (a) FEB 29 1948 (Date received local registrar)  
J. J. Bredeck (Registrar's signature)

23. (a) Signature Cliff Perry (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 3/16/48

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**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 Ralph W. Hanson

Licensed Embalmer No. 3291

P. O. Address St. Louis, MO

**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.**