

No. 300  
M-10-47  
v. 5-17-39  
I 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED APR 7 1948

318

INDIAN DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

10764  
State File No. \_\_\_\_\_  
Registrar's No. 3079

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County St Louis  
(b) City or town St Louis  
(c) Name of hospital or institution: 3615 Lafayette  
(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 Mo (b) County 000  
(c) City or town St Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3615 Lafayette 9  
(If rural, give location)  
(e) Citizen of foreign country? 17 (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William H Tospon  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 3 day 30 -  
year 1948 hour 4 minute 30-9 M.  
21. I hereby certify that I attended the deceased from 4th  
March 1948 to 3-30 1948  
that I last saw ~~him~~ alive on 3-23 1948  
and that death occurred on the date and hour stated above.

4. Sex M O 5. Color or race W  
6. (a) Single, widowed, married, divorced M I  
6. (b) Name of husband or wife Lillian  
6. (c) Age of husband or wife if alive 54 years  
7. Birth date of deceased June 13 1873  
(Month) (Day) (Year)

Immediate cause of death Thromboplegia  
Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years 74 Months 9 Days 17  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions Hypertension  
(Include pregnancy within 7 months of death)

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

10. Usual occupation Restaurant Business

11. Industry or business  
12. Name Not Known 9  
13. Birthplace Not Known (State or foreign country)  
14. Maiden name Not Known 9  
15. Birthplace Not Known (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Lillian Tospon  
(b) Address 3615 Lafayette

17. (a) Burial (b) Date thereof 4/1/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St Peters Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director J L Ziegenhein & Sons  
(b) Address 2027 Gravois Ave.

19. (a) MAR 30 1948 (b) J. F. Brebeck  
(Date received local registrar) (Registrar's signature)

23. Signature J. F. Brebeck (M. D. or other)  
Address 2570 S. Thompson Highway Date signed 3-30-48

(Licensed Embalmer's Statement on Reverse Side)

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

0  
17  
9

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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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7027 Gravois

**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.**