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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED DEC 14 1948

318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 38150
Registrar's No. 10478

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution:
2801 a Thomas St.
(d) Length of stay: 8 Yrs
In this community 8 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County San
(c) City or town St. Louis
(d) Street No. 2801 a Thomas St.
(e) Citizen of foreign country? no

3: (a) PRINT FULL NAME William Spencer Gigger

3. (b) If veteran, name war None 3. (c) Social Security No. 702-18-7694

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Joesphine Spencer Gigger 6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased June 1st, 1884

8. AGE: Year 64 Months 5 Days 29 If less than one day hr. min.

9. Birthplace Greenville Miss.

10. Usual occupation Train Porter

11. Industry or business Frisco R.R.

12. Name Dockknr Gigger

13. Birthplace Unknown

14. Maiden name Martha Spencer

15. Birthplace Unknown

16. (a) Informant Joesphine Spncer Gigger

(b) Address 2801 A. Thomas St.

17. (a) Burial (b) Date thereof 12-4-48

(c) Place: burial or cremation Oak Dale Cem.

18. (a) Signature of funeral director Ellis Fun. Home

(b) Address 2820 Stoddard St.

19. (a) DEC 2 1948 (b) J. B. Lanster

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 28
year 1948 hour 3/45 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Crown Occlusion
Crown Illness
Due to Quadruple prosthesis

Other conditions 95
(Include pregnancy 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) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature J. B. Lanster (Specify type of place) _____
While at work? _____ (e) Means of injury 3
Address _____ Date signed 11/29/48

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

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

Amys

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 *Fulton E Culkin*

Licensed Embalmer No. *4198*

P. O. Address *St Louis 13, 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.