

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25421**
Registrar's No. **6605**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1229

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Hosp-1		d. STREET ADDRESS (If rural, give location) 305 1/2 Luda & Av.	

3. NAME OF DECEASED (Type or Print) William		4. DATE OF DEATH (Month) (Day) (Year) 7 16 49	
5. SEX Male		6. COLOR OF HAIR Black	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH unk - abt 1863	
9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) unk	
11. BIRTHPLACE (State or foreign country) unk		12. CITIZEN OF WHAT COUNTRY? unk	

13a. FATHER'S NAME unk		13b. MOTHER'S MAIDEN NAME unk		14. NAME OF HUSBAND OR WIFE unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) unk		16. SOCIAL SECURITY NO. unk		17. INFORMANT'S SIGNATURE OR NAME James E. Taylor	
				ADDRESS 1300 Clark	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heunorrhage due to gunshot wound of brain self inflicted		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) unk		DUE TO (c) unk	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		305 Luda Av July 11, 1949 at 12:20 PM		Hotel	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	

21a. ACCIDENT (Specify) suicide		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis MO	
21d. TIME OF INJURY (Month) (Day) (Year) 7 16 49		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Self inflicted	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ from the causes and on the date stated above.

23. SIGNATURE Walter Perry Dept. Comm		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 7/30/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE JUL 31 1949		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) _____		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.		ADDRESS 4104 Manchester Ave. St. Louis 10, Mo.	

DATE REC'D BY LOCAL REG. **JUL 31 1949** REGISTRAR'S SIGNATURE **J. B. Sasata**
(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Ralph M. Howell

Licensed Embalmer No. _____

379
J. Trustad

P. O. Address _____

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.