DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

791

State File No. 37768

Registration District No. 1003 Primary Registration District No.

Registrar's No. 9607

1. PLACE OF DEATH:

(a) County 2

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2847 Arlington Ave.
(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: 1

(a) State Missouri (b) County

(c) City or town St. Louis -6-
(If outside city or town limits, write "RURAL")

(d) Street No. 2847 Arlington Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME William P. Mounts 532

3. (b) If veteran, name war No.

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mary Ellen Mounts

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased March (Month) 9, (Day) 1863 (Year)

8. AGE: Years 76 Months 8 Days 0 If less than one day hr. min.

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

10. Usual occupation Carpenter 8

11. Industry or business 4

FATHER
12. Name Joseph Mounts 1
13. Birthplace England (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name McCason Mo.
15. Birthplace England (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary E. Mounts
(b) Address 2847 Arlington Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13/39. (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Jos. W. Clark.
(b) Address 1125 Hodiamont Ave.

19. (a) NOV 10 1939 (Date received local registrar) (b) J. F. Budick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9
year 1939 hour 6 minute 15 P. M.

21. I hereby certify that I attended the deceased from , 19 , to , 1939;
that I last saw him alive on , 1939;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Coronary Sclerosis;	
Due to Arterio Sclerosis;	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? 4 (Specify type of place)
While at work? (e) Means of injury

23. Signature Alfred Perry (M. D. or other)
Address Deputy Coroner Date signed 11.10.39

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 I X19511

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.....

me....., Registered Apprentice No.....,

working under my personal supervision.

Signed John Netter

Licensed Embalmer No. 3883

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, above space should be left blank.