

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.

Registration District No. **1791**
1003

Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(c) Name of hospital or institution: City Sanitarium
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution 1 yr. 6 mos.
In this community 29 yrs.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William Monroe Bruce
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 27 1870
(Month) (Day) (Year)

8. AGE: Years 69 Months 0 Days 1
If less than one day hr. _____ min. _____

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

10. Usual occupation Barber
Barber

11. Industry or business _____

MOTHER FATHER { 12. Name Solomon S. Bruce
13. Birthplace Shawneetown Illinois
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Alvira Randolph
15. Birthplace Shawneetown Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]
(b) Address 5400 Arsenal St
17. (a) Burial (b) Date thereof 12/30/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews
18. (a) Signature of funeral director [Signature]
(b) Address 2301 Lafayette

19. (a) DEC 24 1939 (b) [Signature]
(Date) (Time) (Year) (Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St. Louis 25
(If outside city or town limits, write "RURAL")
(d) Street No. 1413 Olive St
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28
year 1939 hour 10:45 minute a.m. M.

21. I hereby certify that I attended the deceased from 11-15, 1939 to Dec. 28, 1939
that I last saw him alive on Dec. 28, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Pulmonary Embolism</u>	<u>12-26-39</u>
<u>Pulmonary Edema</u>	<u>12-26-39</u>
Due to <u>Uremia</u>	<u>12-26-39</u>
<u>Aortitis</u>	<u>11-15-39</u>
Due to <u>Arteriosclerotic Kidney</u>	<u>11-15-39</u>

Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy Yes 131
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury [Signature]
23. Signature Harry Baers (M. D. or other)
Address City Sanitarium Date signed _____

MAR 14 1955

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.....

Paul A. Keith

Licensed Embalmer No. *3612*

P. O. Address. *2301 Lafayette*

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.