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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 25 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26752

Registration District No. 791 | Primary Registration District No. 1003 | Registrar's No. 6648

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: City Infirmary (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8yr.8mo.28days (Specify whether years, months or days)

In this community 64 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 13 (If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal (If rural, give location)

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

3. (a) PRINT FULL NAME William Washington 252

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased May (Month) 31 (Day) 1865 (Year)

8. AGE: Years 75 Months 2 Days 2 If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business

MOTHER FATHER

12. Name Edward Washington

13. Birthplace Unknown (City, town, or county) Ky. (State or foreign country)

14. Maiden name Mary Fitzgerald

15. Birthplace Unknown (City, town, or county) Ill. (State or foreign country)

16. (a) Informant's own signature J. L. Sullivan

(b) Address 5800 Arsenal St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/40 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Macker-Tedderle

(b) Address 2331 S. Broadway

19. (a) AUG 5 1940 (Date received local registrar) (b) J. F. Buckley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 2 year 1940 hour 11:00 minute P. M.

21. I hereby certify that I attended the deceased from Nov. 5, 1931 to August 2, 1940 that I last saw him alive on August 2, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative Heart Disease

Due to Arteriosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

Duration

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 None

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Geo. L. Boyle M.D. (M. D. or other)

Address City Infirmary Date signed

(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.....

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

working under my personal supervision.

Signed Robert Cwheeler

Licensed Embalmer No. 2128

P. O. Address St Louis M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.