

FILED NOV 29 1944

Primary Registration District No. **3069**

Registrar's No. **2291**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Marys Hospital
(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

3. (a) PRINT FULL NAME WILLIAM DONALD ESCOTT

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased January 27 1930
(Month) (Day) (Year)

8. AGE: - Years Months Days If less than one day
14 9 10 _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name William Edwin Escott
13. Birthplace Paducah Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Fannie May Espy
15. Birthplace Headland Alabama
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. William E. Escott

(b) Address 7434 Lynn Ave., University City

17. (a) burial (b) Date thereof 11/10/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director C. R. Lupton & Sons

(b) Address 7253 Delmar Bly'd., St. Louis

19. (a) NOV 9 1944 (b) G. S. McLawrance
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 7434 Lynn Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 7th
year 1944 hour 6 minute 10 P.M.

21. I hereby certify that I attended the deceased from 10-30 1944 to 11-7 1944
that I last saw him alive on 11-7 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure 2 wks
Duration
Due to Congenital anomaly of heart.
Due to _____

Other conditions (Include pregnancy within 3 months of death) 157 E

Major findings: Of operations _____
Of autopsy See above

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? _____

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

23. Signature G. Lee Shrader (M. D. or other) _____
address 3720 Washington Blvd. Date signed 11-8-44

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

76
309

Dr. E. Lee Shrader,
3720 Washington Blvd.,
NE-6146

1 to 3 p.m.

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

Clarence A. Murray

Licensed Embalmer No. *4011*

P. O. Address. *St. Louis, 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.