

S. No. 2
FORM-5-43
REV. 5-17-39
I X36571

3336

State File No. _____

FILED FEB 13 1945

Registration District No. _____

Primary Registration District No. 6076

Registrar's No. 2859

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

1. PLACE OF DEATH:

(a) County St. Louis Co.

(b) City or town Riverview Gardens
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Home 463 Scenic Dr.
(If not in hospital or institution, write street number or location)
none

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days 5 yr. /

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis Co.

(c) City or town Riverview Gardens
(If outside city or town limits, write "RURAL")

(d) Street No. 463 Scenic Dr.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME William H. Darracott

3. (b) If veteran, name war none

3. (c) Social Security No. 488-05-8957

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Elenora Darracott

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased July 16 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>49</u>	<u>6</u>	<u>5</u>	hr. _____ min.

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

10. Usual occupation Superintend

11. Industry or business James Darracott

MOTHER FATHER { 12. Name _____

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

14. Maiden name Carrie Grabb

15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Elenora Darracott

(b) Address 463 Scenic Dr.

17. (a) Burial (b) Date thereof Jan. 24 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Pickers Cemetery

18. (a) Signature of funeral director Diedrich P. Howe

(b) Address 8319 Halls Ferry Rd.

19. (a) 1/23/45 (b) E. S. McLauren
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 21
year 1945 hour 9 minute 40 A.M.

21. I hereby certify that I attended the deceased from Death without
Medical Attendance to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to _____	Duration
Due to _____	
Due to _____	
Other conditions _____ (Include pregnancy within 3 months of death)	

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations _____

Of autopsy No autopsy

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 [Signature] M.D. (M. D. or other)

Address 601 Brentwood Blvd. Date signed 1/23/45

FEB 20 1945

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.....

G. W. Wilkinson
Licensed Embalmer No. *3575*

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.