S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 9 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15119

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4886

1. PLACE OF DEATH:

(a) County

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

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

(d) Length of stay: In hospital or institution 3yrs. 3mos. 1da. (Specify whether In this community 47 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME WILLIAM FORREST

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 26, (Day) 1864 (Year)

8. AGE: Years 80 Months 7 Days 15 If less than one day hr. min.

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

10. Usual occupation Cook

11. Industry or business

FATHER
12. Name Clifton Forrest
13. Birthplace not known (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lizzie Wheeler
15. Birthplace not known (City, town, or county) (State or foreign country)

16. (a) Informant City Sanitarium Record

(b) Address 5400 Arsenal St.

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 5-18-45 (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director W. Richter

(b) Address 5800 Kutzer

19. (a) JUN 1 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

844

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11th year 1945 hour 12.15 minute p M.

21. I hereby certify that I attended the deceased from Feb. 1st, 1944, to May 11, 1945 that I last saw him alive on May 11, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
General Arteriosclerosis	1942x
Chronic Myocarditis	1942x
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy no

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 Palmer Ransom Bowdish (M. D. or other)

Address 5400 Arsenal St Date signed 5/15/45

(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.....

Licensed Embalmer No.....

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.