

**FILED** **DEC 28 1945**  
Registration District No. **3**

Primary Registration District No. **6676**

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**  
(b) City or town **Rural**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Halls Ferry Memorial**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **6 months**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **020**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **York Hotel - 6th & Market**  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)

3. (a) PRINT FULL NAME **William G. Breck;**

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

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

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **1875** years

7. Birth date of deceased **About** (Month) (Day) (Year)

8. AGE: Years **About 70** Months Days If less than one day hr. min.

9. Birthplace **Mass.** (City, town, or county) (State or foreign country)

10. Usual occupation **Retired Railroad**

11. Industry or business **Freight Traffic**

12. Name **Unknown - Breck**

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

14. Maiden name **Unknown** (City, town, or county) (State or foreign country)

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

16. (a) Informant **Arch Catlett**

(b) Address **B. & O. Railroad**

17. (a) **Burial** (b) Date thereof **12/11/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla**

18. (a) Signature of funeral director **Russell Dickerson**

(b) Address **1431 Union Boulevard**

19. (a) **12-11-45** (b) **W. S. Garrison**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **11** year **1945** hour **8** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **June 6, 1943** to **Dec 11, 1945** and that death occurred on the date and hour stated above.

Immediate cause of death **Cholera and Typhoid** Duration

Due to **Hypertension**

Due to **131**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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) (e) Means of injury

23. Signature **W. S. Garrison** (M. D. or other)

Address **Lindell Trust Bldg** Date signed **12-11-45**

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

Wm. H. Miller

Demetrius Trout-Bell

Grand Street

2729 W. Belmont

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: *Demetrius Trout-Bell*

Licensed Embalmer No. 2915

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. 2837

Registration District No. 307 Primary Registration District No. 6076

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town..... St Louis  
(c) Name of hospital or institution..... St Louis  
Halls Ferry Memorial  
(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 G. Beck  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced..... wid  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....  
7. Birth date of deceased..... abt (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
abt 70 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....  
13. Birthplace..... (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Date received local registrar)..... (b) (Registrar's signature).....

2. USUAL RESIDENCE OF DECEASED:  
(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 11  
year 1945 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... to....., 19.....  
that I last saw him..... and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Chronic Nephritis  
Due to.....  
Due to.....

Other conditions..... (Include pregnancy within 3 months of death)  
Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
Of operations.....  
Of autopsy.....

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) (c) Means of injury.....

23. Signature..... (M. D. or other)  
Address..... Date signed.....

SUPPLEMENTARY

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

42363

BY n Sharny  
Tindell Trust  
add  
58-2  
Chase