

**FILED OCT 7 1946**  
**STANDARD CERTIFICATE OF DEATH**

31402/

State File No. 0

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2010

**1. PLACE OF DEATH:**

(a) County St. Louis  
(b) City or town Coles  
(c) Name of hospital or institution: Robert Wood Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 184 days  
In this community 24 years  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County 000  
(c) City or town St. Louis  
(d) Street No. 3934 Lafayette  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country.

**3. (a) PRINT FULL NAME**

William FORTNER

3. (b) If veteran, name war

3. (c) Social Security No. 494-05-1856

4. Sex M 5. Color or race wh 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Jane Fortner 6. (c) Age of husband or wife if alive 91 years

7. Birth date of deceased 10-14-79  
(Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days 13  
If less than one day hr. min.

9. Birthplace Iron da G Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation mic

11. Industry or business

12. Name Benjamin Fortner

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

14. Maiden name Jane

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

16. (a) Informant Robert Wood Hospital records  
(b) Address

17. (a) Burial (b) Date thereof 9-30-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Picker Cemetery

18. (a) Signature of funeral director Thos. J. Finan  
(b) Address 1519 S. Grand Blvd

19. (a) 9-30-46 (b) Robert Allen  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH, Month September day 27  
year 1946 hour 10 minute - M.

21. I hereby certify that I attended the deceased from 5-3, 1946, to 9-27, 1946; that I last saw h.c.m. alive on 9/27, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Chloroform Poison, Tubercular  
Duration 2 1/2 years

Due to 138

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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) (e) Means of injury 1

23. Signature John F. Galis (M. D. or other)

Address Robert Wood Hospital Date signed 9/27/46

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

MOTHER FATHER

Dr. J. J. Kalish

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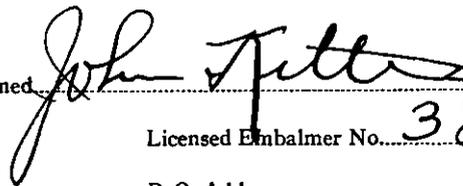
**STATEMENT BY LICENSED EMBALMER**

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.....

3880

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.**