

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. **517** Primary Registration District No. **3063**

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. Louis Co. Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 Days.
(Specify whether)

In this community 58 years.
years, months or days

3. (a) PRINT FULL NAME William. Garlich.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex <u>M</u>	5. Color or race <u>Wh</u>	6. (a) Single, widowed, married, divorced <u>Divorced</u>
6. (b) Name of husband or wife _____	6. (c) Age of husband or wife if alive _____ years	
7. Birth date of deceased. <u>12</u> (Month) <u>10</u> (Day) <u>1889</u> (Year)		

8. AGE: Years <u>58</u>	Months <u>2</u>	Days <u>10</u>	If less than one day _____ hr. _____ min.
-------------------------	-----------------	----------------	---

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

10. Usual occupation Automobile Mechanic

11. Industry or business _____

MOTHER FATHER

12. Name John William Garlich

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

14. Maiden name Sophie Williams

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

16. (a) Informant Gene Becker

(b) Address 436 W. Rosehill, Kirkwood, Mo.

17. (a) 1947 (Burial, cremation, or removal) (b) Date thereof 2-24-47 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Louis H. Boyer, Inc.

(b) Address 131 W. Argonne Dr. Kirkwood, Mo.

19. (a) 2-25-47 (Date received local registrar) (b) Paul J. Allen M.D. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. Harrison & Essex
(If rural, give location)

(e) Citizen of foreign country? N.O. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20 year 1947 hour 5 minute 10 P. M.

21. I hereby certify that I attended the deceased from 2-12-47 to 2-20-47 that I last saw him alive on 2-20-47 and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure Duration _____

Due to lobar pneumonia R.L.

Due to arteriosclerotic cardiovascular disease - decompensation

Other conditions (include pregnancy within 3 months of death) 156

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 _____

23. Signature Wm. C. Citchlow (M. D. or other) 2/21/47
Address 601 Brentwood Blvd. Date signed _____
Clayton

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

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..... *Felix Almand*

Licensed Embalmer No. *3034*

P. O. Address *1 Kirkwood (22) 7*

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.