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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 22 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19433**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4780**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis Mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1722 N. 20th Str
(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 Frank Thro

3. (b) If veteran, name war _____ 3. (c) Social Security No. 498-09-7189

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

6. (b) Name of husband or wife Nancey Thro 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 9 1868
(Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Frank Thro

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

14. Maiden name Josephine Thro

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

16. (a) Informant Nancey Thro

(b) Address 1722 N. 20th Str

17. (a) Burial (b) Date thereof 5/13/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Central Und. Co

(b) Address 1841 Cass ave

19. (a) MAY 12 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
 (c) City or town St Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 1722 N. 20th Str.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11 year 47 hour 4 minute 10 A.M.

21. I hereby certify that I attended the deceased from Oct. 17, 1947 to May 9, 1947 that I last saw him alive on May 9, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 3 days

Due to Uraey Failure (Nephrositis) 2 weeks

Due to Cancer of Prostate & Metastasis 4 years

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

Major findings: 51

Of operations _____

Of 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 _____

23. Signature Doris S Woolsey (M. D. or other) (M.D.)

Address 4800 Hadley Date signed 5-12-47

(Licensed Embalmer's Statement on Reverse Side) Doris S. Woolsey

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

MOTHER FATHER

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..... *W. W. Wilkins*.....

Licensed Embalmer No. 2575

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. June
Registrar's No. 4780

Registration District No. 218

Primary Registration District No. 1003

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

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:

(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 Wm F. Ihuo

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 M

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

7. Birth date of deceased Nov 9 1904
(Month) (Day) (Year)

8. AGE: Years 78 Months 6 Days 10 (If less than one day, hr. min.)

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

10. Usual occupation Unemployed

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) J. F. Breneck
(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 1944 Year 1944 Hour 10 minute 00 M.
21. I hereby certify that I attended the deceased from 1944 to 1944 ;
that I last saw him alive on 1944 ;
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....

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.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

JUN 16 1944

S-19433

11/11/20