

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 30 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22122
6034

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

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:
ST LOUIS CHILDRENS HOSP 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 38 hours
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS 96

(c) City or town OVERLAND 14 mo. 0
(If outside city or town limits, write "RURAL")

(d) Street No. NR RT 7 BOX 519 0
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME William Lee Case

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 19
year 47 hour 5 minute 35 AM

21. I hereby certify that I attended the deceased from
6-17, 1947, to 6-19, 1947;

that I last saw h.l.c. alive on 6-19, 1947;
and that death occurred on the date and hour stated above.

4. Sex MALE (1) 5. Color of race WHITE

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased OCT - 23 - 1935
(Month) (Day) (Year)

Immediate cause of death Pneumonia, Bronch
107.

Due to _____

Due to _____

8. AGE: Years Months Days If less than one day

11	7	26	hr. min.
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9. Birthplace CARTHAGE Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

Other conditions Chronic encephalitis
(Include pregnancy within 3 months of death)
Non-Epidemic

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name WILLIAM C. CASE

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

14. Maiden name LENA E TROMBARGE

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

16. (a) Informant MRS HAROLD GIVIDEN

(b) Address Rt 7 Box 519 - OVERLAND Mo.

17. (a) BURIAL (b) Date thereof 6-23-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PARK Cem. CARTHAGE Mo.

18. (a) Signature of funeral director ROWLAND MORTUARY SERVICE
(Specify type of place)

(b) Address 4355 WASHINGTON AV. (c) Means of injury 0

19. (a) JUN 23 1947 (b) J. F. BREDECK
(Date received local registrar) (Registrar's signature)

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? _____

23. Signature R. J. BEATTIE (M. D. or other) _____
Address _____ Date signed _____

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

5809

JUN 1

1949

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..... 3881

P. O. Address..... St. Louis, Mo.

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.