

5. No. 2
1-1/47
5-17-39

National Office of Vital Statistics
FILED OCT 29 1947
Registration District No. **37**

Primary Registration District No. **3069**

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Richmond Heights, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution St. Mary's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 month
(Specify whether years, months or days)

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. 924 Wood Avenue
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME William N. Terrill
 3. (b) If veteran, name war None (c) Social Security No. 495-20-6094
 4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mary Ella Terrill 6. (c) Age of husband or wife if alive 32 years
 7. Birth date of deceased September 23 1911
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month October day 19 year 1947 hour 8 minute 25 P.M.
 21. I hereby certify that I attended the deceased from April 10/47 to Oct. 19 1947 that I last saw him alive on Oct 19 1947 and that death occurred on the date and hour stated above.
 Immediate cause of death Metastatic Carcinoma Multiple Abscess of Lung Carcinoma of Tongue (Squamous cell)
 Duration 4 1/2 weeks approx 1947

8. AGE:	Years	Months	Days	If less than one day
	<u>36</u>	<u>0</u>	<u>26</u>hr.min.

Due to 45 hr
 Other conditions None
(Include pregnancy within 3 months of death)
 Major findings: as above
 Of operations _____
 Of autopsy as above

8. AGE:

Years	Months	Days	If less than one day
<u>36</u>	<u>0</u>	<u>26</u>hr.min.

 9. Birthplace Huntsville Missouri
(City, town, or county) (State or foreign country)
 10. Usual occupation Purchasing Agent
 11. Industry or business St. Clair Coal Company
 12. Name William H. Terrill
 13. Birthplace Huntsville Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name Viola Scott
 15. Birthplace Bynumville Missouri
(City, town, or county) (State or foreign country)
 16. (a) Informant Mary Ella Terrill
 (b) Address 924 Wood Avenue
 17. (a) Removal (b) Date thereof 10/20/47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Huntsville, Missouri
 18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Blvd.
 19. (a) 10-20-47 (b) Cecil G. Shary
(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? _____ (Specify type of place)
 While at work? _____ (e) Means of injury _____
 Signature John C. Linton (M. D. or other) no
 Address 3720 Washington Date signed 10/20/47

PHYSICIAN

 Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

SEP 25 1948

JUN 9 1948

OCT 8 1948

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 *Ernest W. Spillers*
Licensed Embalmer No. *4080*

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.

Registration District No. 317 Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Richmond Heights
(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 years, months or days)

In this community _____
(Specify whether years, months or days)

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 _____

3. (a) PRINT FULL NAME Wm N. Terrell

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 Sept 23 1919
(Month) (Day) (Year)

8. AGE: Years 36 Months 0 Days 0 (If less than one day, hr. min.)

9. Birthplace mo
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-20-47 (b) Carla J. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: 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 _____ (M. D. or other) _____
Date signed _____

SUPPLEMENTARY

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

S-36545