

No. 300  
-10-47  
5-17-39  
D-I 3906

FEDERAL SECURITY # 88954  
National Office of Vital Statistics  
FILED APR 23 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

13944  
State File No. ....  
Registrar's No. 3597

Registration District No. 318 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, Mo.  
(c) Name of hospital or institution:  
St. Louis City Hospital - Max C. Starkloff  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis 17  
(d) Street No. 3517 Lucas Ave. 9  
Memorial (If rural, give location) 0  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3: (a) PRINT FULL NAME BILL WILLIAM CHARLES  
3. (b) If veteran, name war.....  
3. (c) Social Security No. 497-05-2481

4. Sex Male 0 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Katherine Charles  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased April, ? 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
60 0 ? hr. min.

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

10. Usual occupation Shoe worker

11. Industry or business.....

MOTHER FATHER  
12. Name Constantine Charles  
13. Birthplace Albania (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace Albania (City, town, or county) (State or foreign country)

16. (a) Informant Jim Vangel  
(b) Address 3517 Lucas Ave.

17. (a) Burial (b) Date thereof 4/15/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Matthews Cem.

18. (a) Signature of funeral director CHULICK UND. CO. INC.  
(b) Address 1722 S. Jefferson Ave.

19. (a) APR 25 1948 (b) J. J. [Signature] (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 12th  
year 1948 hour 9 minute 20 P M.  
21. I hereby certify that I attended the deceased from 3/23/48  
to April 12th 19 48  
that I last saw him alive on April 12th 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death carcinoma of stomach  
Duration 1 + yr  
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?..... Means of injury.....  
23. Signature Carlyle A. [Signature] 1516 Lafayette 4/14/48 (Address) (Date signed)

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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 Alex A. Chulick Jr

Licensed Embalmer No. 4143

P. O. Address 1722 S. Jefferson

**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.**