

Registration District No. **318**

Primary Registration District No. **1003**

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: Barnes Hospital, 0  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Day  
 (Specify whether  
 In this community 50 years.  
 years, months or days)

3. (a) PRINT FULL NAME William L. Raymond Gifford,

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, <sup>or</sup> divorced, Widowed

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

7. Birth date of deceased November 5, 1862  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>7</u>	<u>17</u>	hr. _____ min.

9. Birthplace Rochester Center, Mass. 1  
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired Librarian.

11. Industry or business \_\_\_\_\_

12. Name Humphrey A. Gifford,

13. Birthplace Rochester Center, Mass. 1  
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown.

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

16. (a) Informant Mrs. Charles Claflin Allen

(b) Address 408 Olive St.

17. (a) cremation. (b) Date thereof 6/25/48  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Wagoner Mortuary

(b) Address 4161 Lindbergh Blvd.

19. (a) 6/22/48 (b) J. H. Redbeck  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 411 North Newstead  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22  
 year 1948 hour 3 minute 35 P. M.

21. I hereby certify that I attended the deceased from 1945, 19\_\_\_\_, to June 22, 1948, 19\_\_\_\_;  
 that I last saw him alive on June 22, 1948, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_  
Gastro-intestinal hemorrhage, massive. 48 hrs.

Due to ulceration of choroid plexus of 2nd portion of lumbosacrum.

Due to \_\_\_\_\_

Other conditions Carcinoma of Prostate 1  
 (Include pregnancy within 3 months of death)

Major findings: Of operations 51

Of autopsy as above

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) Means of injury \_\_\_\_\_

23. Signature James E. Yagge, M.D. (M. D. or other)

Address Barnes Hospital Date signed \_\_\_\_\_

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 *Robert T. Sangster*

Licensed Embalmer No. *4290*

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July  
Registrar's No. 56

Registration District No. 318

Primary Registration District No. 1003

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

William L R Gifford

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: wid

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive: 36

7. Birth date of deceased: Nov-5-1906  
(Month) (Day) (Year)

8. AGE: Years 85 Months 7 Days 2 If less than one day, hr. 0 min. 0

9. Birthplace: Moos  
(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) (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) 6-24-48 (b) J. F. Brodeur  
(Date received local registrar) (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 July 21. I hereby certify that I attended the deceased from 1945 to July 2  
year 1945 hour 10 minute 2 M.

21. I hereby certify that I attended the deceased from July 2 to July 2  
that I last saw him alive on July 2 19.....  
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

5-20881