

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 23 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34771**
Registrar's No. **8894**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(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: St. Louis City Hospital—Max C. Starkloff
(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)

In this community 20 years

3. (a) PRINT FULL NAME WILLIAM TODD

3. (b) If veteran, name war ~

3. (c) Social Security No. 493-24-9055

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

6. (b) Name of husband or wife Carolyn 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased July 1 - 1872
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>3</u>	<u>11</u>	hr. min.

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

10. Usual occupation Landscape Gardener

11. Industry or business Retired

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Fred A. Todd

(b) Address 3156 Clifton Ave

17. (a) Cremation (b) Date thereof 10-15-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director A W McLaughlin

(b) Address 2301 Lafayette Ave

19. (a) OCT 13 1948 (b) J. B. Fosater
(Date received) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4149 Maryland Ave
(If rural, give location)

(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Scotland

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12th
year 1948 hour 3 minute 42 P.M.

21. I hereby certify that I attended the deceased from 9/15/48
1948 to Oct. 12th 1948

that I last saw h. im alive on Oct. 12th 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
(Specify type of disease)

Due to 107

Due to senile psychosis

Other conditions senile psychosis
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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? Frank F. [unclear]
(Specify type of place)

23. Signature 1515 Lafayette 10/15/48 other) _____
Address _____ Date signed _____

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.....

E W Cooper

Licensed Embalmer No.....

3830

P. O. Address.....

2301 Lafayette

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.