

No. 300
A-10-47
5-17-39
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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED OCT 18 1948

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

34815
State File No. _____
8695
Registrar's No. _____

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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks
(Specify whether _____)
In this community 28 years
(years, months or days)

3. (a) PRINT FULL NAME William H. Wasson
3. (b) If veteran, name war Nil **3. (c) Social Security No.** _____

4. Sex Male **5. Color or race** White
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Cora
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased January 25 1873
(Month) (Day) (Year)

8. AGE: Years 75 Months 8 Days 7
If less than one day _____ hr. _____ min.

9. Birthplace Omaha Illinois
(City, town, or county) (State or foreign country)
10. Usual occupation Process server

11. Industry or business Hay-Flanagan Attorneys
12. Name Benjamin Wasson
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name Mary Jane Wasson
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Raymond Wasson
(b) Address 1829a Allen Avenue
17. (a) Burial Mount Hope Cemetery
(Burial, cremation, or removal) **(b) Date thereof** 10-5-48
(Month) (Day) (Year)
(c) Place: burial or cremation Mount Hope Cemetery
18. (a) Signature of funeral director A. W. Mc Laughlin
(b) Address 2301 Lafayette Avenue
19. (a) OCT 6 1948 **(b) J. B. Sasater**
(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. 1317 Allen Avenue
23 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 2nd.
year 1948 hour 5:45 minute 5M.
21. I hereby certify that I attended the deceased from Sept 13, 1948 to Oct 2, 1948
that I last saw him alive on Oct 1, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary failure
Due to Myocarditis cur
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: Ca of gall bladder
Of operations _____
Of autopsy none

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 Richard S. Kueffer (M. D. or other) _____
Address 7500 Olive Date signed 10/4/48

Dr. Roland Kieffer
4500 Olive
Forest 3800

8698

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.....

Signed..... *R P Cooper*

Licensed Embalmer No..... *3633*

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.