

No. 300
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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED JAN 11 1949

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

41309

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11327**

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

1. PLACE OF DEATH:

(a) County St. Louis Mo.
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Hosp #1
 (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 Britt

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased: (Month) _____ (Day) 18 (Year) 1896

8. AGE	Years	Months	Days	If less than one day
<u>57</u>	<u>12</u>			hr. _____ min. _____

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

10. Usual occupation work

11. Industry or business work

12. Name her self

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

14. Maiden name _____

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

16. (a) Informant: W. T. Sprague
 (b) Address 1300 Park
 (c) Place: burial or cremation Anatomical Board

17. (a) Signature of funeral director Rowland Mortuary Service
 (b) Address 4104 Manchester Ave.
 (c) Date received local registrar DEC 31 1948 (b) Date thereof DEC 31 1948 (Month) (Day) (Year)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 28 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Nov, day 22, year 1948 hour 3:30 p.m.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____; that I last saw him _____ alive on _____ 19 _____ and that death occurred on the date and hour stated above

Immediate cause of death: Fracture of Skull
2 1/2" Fracture of Skull
when he walked into the side of a automobile driven by one Leonard E. Frackley
about 10, or P. M., Nov. 17, 1948

Due to _____
 Due to _____
 Other conditions _____ (Include necessary within 3 months of death)

PHYSICIAN

Major findings: accident
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) accident
 (b) Date of occurrence Nov 17 1948
 (c) Where did injury occur? St. Louis Mo (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 3

23. Signature W. T. Sprague (M. D. or other) _____
 Address 1300 Park Date signed 12/1/48

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 *Ralph W Henson*.....

Licensed Embalmer No. *3791*.....

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.

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) (Specify whether

3. (a) PRINT FULL NAME Wm Butt
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 unk

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: all 72 Years Months Days If less than one day..... hr. min

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name..... (City, town, or county) (State or foreign country)

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) 12-31-48 (b) J B Lester (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 January 2
year 1948 hour..... minute..... M.

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

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

SUPPLEMENTARY

S-41309