

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 4 1940

Registration District No. 784

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 115

State File No.

19591

Registrar's No. 1036

1. PLACE OF DEATH:

(a) County. St. Louis
(b) City or town. University City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6272 Enright Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9
(Specify whether years, months or days)
In this community. 30 years

3. (a) PRINT FULL NAME CHARLES W. JAMES 520
8. (b) If veteran, name war NO 8. (c) Social Security No. 495-14-5004

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife. Emma James 6. (c) Age of husband or wife if alive unobtainable
7. Birth date of deceased September 20, 1871 able
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 8 11 hr. min.

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

10. Usual occupation retired Mail Clerk

11. Industry or business

FATHER { 12. Name Thomas M. James
13. Birthplace Ramsey Illinois
(City, town, or county) (State or foreign country)
MOTHER { 14. Maiden name Harriet C. Blankenship
15. Birthplace Ramsey Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Emma James
(b) Address 6272 Enright Ave.

17. (a) burial (b) Date thereof 6/3/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Vandalia, Ill.

18. (a) Signature of funeral director Alexander & Sons Inc.
(b) Address 6175 Delmar Blvd.

19. (a) JUN - 1 1940 (b) P. R. Meyer M.D.
(Date received from Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 6272 Enright Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. — years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month May day 31 year 1940 hour 8:20 minute 30
21. I hereby certify that I attended the deceased from July 23rd to May 31, 1940
that I last saw him alive on May 30, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Traumatic Hepatitis
Due to Fall at Muri Theatre
Arterial Thrombosis
Due to Cardiac Decompensation

Other conditions —
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

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? 70'
(Specify type of place) While at work — Means of injury —

23. Signature Halter J. Gosh (M. D. or other) —
Address 6635 Delmar Date signed 5-31-40

192 W
192 W

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.....

Albert E. White, Registered Apprentice No. 209,
working under my personal supervision.

Signed

John Bentley

Licensed Embalmer No. 3653

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, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19591
Registrar's No. 1036

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:
(a) County St. Louis City
(b) City or town Union City
(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 Charles J. James
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 M
6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

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

9. Birthplace (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) (Date received local registrar) (b) (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) If foreign born, how long in U. S. A. ? years.

20. DATE OF DEATH Month May day 31 year 1940 hour 4 minute 0 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 Transtrumatic hepatitis
Fall at Movie opera -
Femoral Thromb -
Cardiac Decomp -
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: 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 7-24-39
(c) Where did injury occur? Municipal opera house
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place
While at work? (Specify type of place) (e) Means of injury Struck right side in stage

23. Signature H. B. York (M. D. or other) M.D.
Address 6635 Delinger - St Louis Date signed 7-12-40

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

