

Registration District No. **1003**

Primary Registration District No. **1003**

Registrar's No. **9931**

1. PLACE OF DEATH:

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

8. (a) PRINT FULL NAME Joseph Lindsay

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced, single

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

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

8. AGE: Years 55 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation laborer _____

11. Industry or business _____

12. Name unknown _____

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 John Judge - P.D.

(b) Address 928 N. Balfour

17. (a) _____ (b) Date thereof 11-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington D.C.

18. (a) Signature of funeral director W. R. Ruckert

(b) Address 3500 Rutledge

19. (a) DEC 4 1940 (b) J. H. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis 2d
(If outside city or town limits, write "RURAL")
(d) Street No. 2207 Chestnut
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 20
year 1940 hour 7:5 minute 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 _____

Primary thromboses

Due to Heart Infarct

Due to Septicemia of Heart

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? _____

While at work? _____ (Specify area of place) _____
23. Signature Joseph M. ... (M. D. or other) _____
Address Deputy ... State signed _____

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

MOTHER FATHER

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.