

Registration District No.
Primary Registration District No. 1002

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:
Alexian Brothers 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Jackson
(c) City or town Murphysboro
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country?
If yes, name country

3. (a) PRINT FULL NAME James A White

3. (b) If veteran, name war
3. (c) Social Security No. none

4. Sex M 5. Color or Face W
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 September 25, 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 6 6 hr. min.

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

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER { 12. Name unknown White
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edna Tindell

(b) Address Murphysboro, Ill.

17. (a) Removal (b) Date thereof 4/3/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Murphysboro, Ill.

18. (a) Signature of funeral director Albert H. Hoppe Inc

(b) Address 4700 Washington Blvd.

19. (a) APP - 1942 (b) J. J. Bredek
(Date received local) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31
year 1943 hour 8:20 minute 0 M.

21. I hereby certify that I attended the deceased from March 27, 1943, to March 31, 1943.
that I last saw him alive on March 31, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death
Lobar Pneumonia
Rt. Middle + Lower

Duration
5 days

Due to

Due to Arterio Sclerosis / 108

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 J. Hayden (M. D. or other) MD
Address 5899 Pleasant Date signed 4-3-43

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

1899 Delmar

MOTHER FATHER

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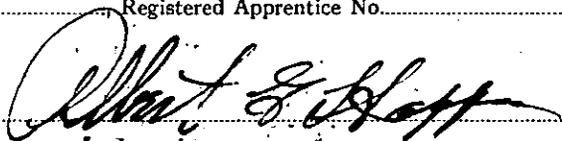
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STATEMENT BY LICENSED EMBALMER

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. 2971

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, fact should be so stated above.