

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

FILED OCT 23 1943

Registration District No. 3069

Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County: St. Louis
(b) City or town: Washington Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital of institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME: REV FR. JAMES MOYE

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

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: Sept. 17, 1868
(Month) (Day) (Year)

8. AGE: Years: 75 Months: 0 Days: 27 If less than one day: _____ hr. _____ min.

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

10. Usual occupation: Clerk

11. Industry or business: _____

12. Name: Unknown

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

14. Maiden name: Unknown

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

16. (a) Informant: Rev Father St. Francis

(b) Address: Big Bend & Seyer Rd

17. (a) Buried (b) Date thereof: Oct 18, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St. Joseph's Cemetery

18. (a) Signature of funeral director: _____

(b) Address: _____

19. (a) OCT 20 1943 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: _____
(c) City or town: Washington Heights
(If outside city or town limits, write "RURAL")
(d) Street No.: Big Bend & Seyer Rd
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct day: 18 year: 1943 hour: 7:35 minute: _____ M.

21. I hereby certify that I attended the deceased from _____ to _____

that I last saw him alive on: Oct 14, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocardial

Due to: Coronary Arteriosclerosis

Due to: Cerebral Thrombosis

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 type of place) _____
Means of injury: _____

23. Signature: James E. Wade M.D. (M.D. or other)

Address: 2040 N. 1st St. St. Louis, Mo. Date signed: 10/16/43

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..... *Harry J. Shemach*

Licensed Embalmer No. *2679*

P. O. Address..... *732 Semarpyrd*

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.