

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Bethesda Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 months  
(Specify whether  
 In this community Life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
 (c) City or town St. Louis, 17  
(If outside city or town limits, write "RURAL") 92V  
 (d) Street No. 1035 Morrison Ave.  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John nie Thomas House

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

4. Sex M 5. Color or race W  
 6. (a) Single, widowed, married, divorced Infant  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased July 1st 1943  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 5 29 hr. \_\_\_\_\_ min.

9. Birthplace St. Louis, Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Paul House

13. Birthplace Peshoke, Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Imogen Allison

15. Birthplace Fulton, Kentucky 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Paul House

(b) Address 1035 Morrison Ave.

17. (a) Burial (b) Date thereof 11/3/1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director A. W. M. Laughlin

(b) Address 2301 Lafayette Ave.

19. (a) DEC 31 1943 J. J. [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 30  
 year 1943 hour 9: minute 55 A.M.

21. I hereby certify that I attended the deceased from Oct. 1  
 1943, to Dec 30, 1943;

that I last saw him alive on Dec 29, 1943;

and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure Duration \_\_\_\_\_

Due to Chronic Interstitial pneumonia 3mo

Due to Influenzal meningitis 3wks

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy Chest only - M+L lobes @ lung  
scarred & adherent to pleura.

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 Richard Y. Wade M.D. (M. D. or other) \_\_\_\_\_

Address 3649 Vista Date signed 12/31/43

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

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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 L. R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

**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.**