

P. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
P I X36671

43399

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JAN 3 1944

Registration District No. 1318

Primary Registration District No. 1003

Registrar's No. 11558

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:  
BARNES HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 1 WK.  
(Specify whether

In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County.....

(c) City or town CENTRALIA - NR.  
(If outside city or town limits, write "RURAL")

(d) Street No. ROUTE 5  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country 2

3. (a) PRINT FULL NAME FLOYD HARLEY PROSISE

3. (b) If veteran, name war None

3. (c) Social Security No. Unk?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 21  
year 1943 hour 1 minute 15 P.M.

21. I hereby certify that I attended the deceased from  
Dec. 14 1943 to Dec. 21 1943;  
that I last saw h. IM alive on Dec. 21 1943;  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eula Prosise 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased: May 25 1904  
(Month) (Day) (Year)

Immediate cause of death.....  
LOBAR PNEUMONIA, BILATERAL Duration  
48 Hrs.

Due to CEREBELLAR CRANIOTOMY

Due to BRAIN TUMOR (FOURTH VENTRICLE)  
non-malignant

Other conditions NONE  
(Include pregnancy within 3 months of death)

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

39	6	26	.....hr. ....min.
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Major findings:  
Of operations TUMOR FILLING 4TH VENTRICLE,  
ATTACHED TO THE FLOOR  
Of autopsy BILATERAL LOBAR PNEUMONIA

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

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

10. Usual occupation Carman

11. Industry or business Illinois Central R.R.

MOTHER FATHER {

12. Name James Prosise

13. Birthplace Unknown Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Lillie Capple

15. Birthplace Unknown Illinois  
(City, town, or county) (State or foreign country)

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?  
..... (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature M. C. Abney (M. D. or other)  
Address BARNES HOSPITAL Date signed 12/21/43

16. (a) Informant Eula Prosise

(b) Address Centralia, Illinois

17. (a) Removal (b) Date thereof 12-22-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Illinois

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

(b) Address 4700 Washington Blvd.

19. (a) Dec 20 (b) J. P. Bradeck  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 17 1945

JAN 17 1945

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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

*Albert G. Koffe*  
.....  
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.**