

FILED JAN 12 1944

318

Primary Registration District No.

1003

Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: BARNES HOSPITAL
(d) Length of stay: In hospital or institution

In this community years, months or days

3. (a) PRINT FULL NAME JEROME HENRY CHRISTY

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

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

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

7. Birth date of deceased August 14 1863
(Month) (Day) (Year)

8. AGE: Years 80 Months 4 Days 17
If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name James Christy

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

14. Maiden name Kathrine Meeks

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

16. (a) Informant Mrs. Frank T. Sagg

(b) Address Edwardsville, Illinois

17. (a) Removal (b) Date thereof 1-3-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cowden, Illinois

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

(b) Address 4700 Washington Blvd.
JAN 3 1944

19. (a) (Date received local registrar) (b) Registrar's signature J. F. Burrell

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Shelby
(c) City or town Cowden
(d) Street No.
(e) Citizen of foreign country? (Yes or No) 2
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 1
year 1944 hour 9 minute - P. M.

21. I hereby certify that I attended the deceased from Dec. 28, 1943, to JAN. 1, 1944;
that I last saw him alive on JAN. 1, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial insufficiency
Due to Arteriosclerotic heart disease
Due to Benign Hypertrophy of prostate
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations Benign Hypertrophy of Prostate
Of autopsy

Duration

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 M. C. Abney (M. D.)
Address BARNES HOSPITAL Date signed

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

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. Hoff*.....

..... 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.