

FILED APR 6 1944
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5845 Etzel Ave.
(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 Mo. (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 9 5
(d) Street No. 5845 Etzel Ave
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Willis Hale Paige

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Louise Paige 6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased Sept. 6 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 6 23 hr. min.

9. Birthplace Boston Mass
(City, town, or county) (State or foreign country)

10. Usual occupation Federal Reserve Clerk

11. Industry or business _____

MOTHER FATHER { 12. Name James Paige
13. Birthplace Mass
(City, town, or county) (State or foreign country)
14. Maiden name Georgette Hale
15. Birthplace Mass.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Louise Paige
(b) Address 5845 Etzel

17. (a) Burial (b) Date thereof 4-1-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hiram Cem.

18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.

19. (a) MAR 30 1944 (b) J. T. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 29
year 1944 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from Feb. 29 1944 to March 29 1944
that I last saw him alive on March 28 1944
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to <u>cerebral arteriosclerosis</u>	<u>6 mos</u>
Due to <u>age</u>	<u>57</u>
Other conditions <u>adrenomedullary tumor, metastatic</u> (Include pregnancy within 3 months of death) <u>and location not known.</u>	
Major findings: Of operations <u>No</u>	
Of autopsy <u>No</u>	

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?

(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature W. J. Hagan Jr. (M. D. or other) D
Address 5828 Pyramont, a Date signed Mar 30/44

12
P.M.
outh
(Ca. 0220)

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

Warren A. Carver

Licensed Embalmer No.

3534

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3025

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: _____

(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)

3. (a) PRINT FULL NAME Willis Hale Paige

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____

7. Birth date of deceased September 5, 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 6 24 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-10-44 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5845 Etzel Ave.
(If rural, give location)

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29th
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that last saw h _____ alive on _____, 19____;

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

Immediate cause of death _____ Duration _____

Due to _____

Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

9338