

FILED JUL 21 1944

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6521**

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

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: **Isolation Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **6/24/44 to 7/6/44** (Specify whether years, months or days)

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

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

(d) Street No. **2712 Delmar** (If rural, give location)

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

3. (a) PRINT FULL NAME **James Powell**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **6th**
year **1944** hour **5** minute **45** A.M.

21. I hereby certify that I attended the deceased from **6/24**, 19 **44** to **7/6**, 19 **44**

4. Sex **Male**

5. Color or race **Colored**

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 _____
(Month) (Day) (Year)

that I last saw him alive on **7/6**, 19 **44** and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumococcal meningitis, type III** Duration

8. AGE:

Years	Months	Days	If less than one day
abt 70	-	-	hr. min.

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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)

Major findings:
Of operations _____

Of autopsy **none**

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

16. (a) Informant **Stella Grady**
(b) Address **5800 Arsenal St.**

17. (a) **Burial** (b) Date thereof **7-13-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **City Cemetery**

18. (a) Signature of funeral director **J. F. Ryan**
(b) Address **5800 Arsenal**

19. (a) **JUL 13 1944** (b) **J. F. Ryan**
(Date received local registrar) (Registrar's signature)

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 **J. P. Maxa** (M. D. or other) _____
Address **Isolation Hosp.** Date signed **7-12-44**

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.....

Licensed Embalmer No.....

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.