

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:
DE PAUL HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 MO.
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Mad
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 1427 S. 9TH STR.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME REV. WILLIAM P. PONET C.M.

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

4. Sex MALE 5. Color or race WHITE 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 MARCH - 25 - 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace LOS ANGELES CALIF.
(City, town, or county) (State or foreign country)

10. Usual occupation PRIEST

11. Industry or business _____

12. Name VICTOR PONET

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

14. Maiden name ELLEN MANNING

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

16. (a) Informant Rev. Skinnig C.M.

(b) Address 1427 S. 9th St.

17. (a) BURIAL (b) Date thereof 12-2-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (c) Signature of funeral director Bullen + Kelly

(b) Address 4386 Lindell Blvd

19. (a) DEC 1 1944 (b) J. F. Bredas
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 29
year 1944 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dec. 2 1941 to Nov. 29 1944
that I last saw him alive on Nov. 29 1944
and that death occurred on the date and hour stated above.

Immediate cause of death. Terminal Broncho Pneumonia Degenerative Myocarditis

Due to _____
Due to _____

Other conditions Carcinoma of head
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 George A. Carney (M. D. or other) _____

Address 607 N. 9th St. Date signed 11/20

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *Clement McManis*

Licensed Embalmer No. *3732*

P. O. Address *St Louis*

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.