

FILED JAN 16 1945
318

Registration District No. _____ Primary Registration District No. **1002** Registrar's No. **83**

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:
1020 Morrison
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **None** (Specify whether _____)

In this community **21 Years** / (Specify whether _____
years, months or days)

3. (a) PRINT FULL NAME **Frank Jean Charleville**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

4. Sex **Male** / 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mary**

6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **June 16 1861**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	83	6	18	hr. _____ min. _____

9. Birthplace **Bloomsdale Mo.** **Missouri** D
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Retired**

12. Name **Charles Charleville**

13. Birthplace **Missouri** D
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Labumndier**

15. Birthplace **Missouri** D
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary Charleville**

(b) Address **1020 Morrison**

17. (a) **Burial** (b) Date thereof **1/6/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **A. W. McLaughlin**

(b) Address **2301 Lafayette Ave.**

19. (a) **JAN 4 1945** (b) **J. F. Bredish**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(If outside city or town limits, write "RURAL")

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

(d) Street No. **1020 Morrison**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **4**
year **45** hour **7** minute **30-A** M.

21. I hereby certify that I attended the deceased from **Dec 6, 1944**, to **Jan 4, 1945**
that I last saw him alive on **Jan 3, 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Chronic Myocarditis

Due to _____

Diabetes mellitus

Due to _____

Senile Debility

Other conditions **Senile Debility**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

61

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 **A. F. Ruppel** (M. D. or other) _____

Address **905 Morrison** Date signed **1/4/45**

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

MOTHER FATHER

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 L. R. Cooper

Licensed Embalmer No. 2633

P. O. Address 2317 Lafayette

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.