

FILED JAN 16 1945
Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2715

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Pine Lawn
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 9/1
(c) City or town Pine Lawn Mo. 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. 3515 Manola Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME William M. Michael

3. (b) If veteran, name war No 3. (c) Social Security No. 494-07-4254

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

6. (b) Name of husband or wife Ellen Michael 6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased Feb. 28th 1889
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>9</u>	<u>14</u>	hr. _____ min.

9. Birthplace St. Paul Minn. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter & Painter

11. Industry or business

12. Name Joseph A. Michael
13. Birthplace Unknown 0
(City, town, or county) (State or foreign country)
14. Maiden name Ellen Meyer
15. Birthplace Unknown 0
(City, town, or county) (State or foreign country)

16. (a) Informant Carl Jungling
(b) Address 3515 Manola
17. (a) burial (b) Date thereof 12/18/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Mark Tiernon
(b) Address 6100 W. Esplanade
19. (a) DEC 18 1944 (b) A. W. McCausland (Registrar's signature) Address 390 National Bridge

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 18 year 1944 hour 8 minute _____ M.

21. I hereby certify that I attended the deceased from 10/15 to Dec 7th, 1944
that I last saw him alive on Dec 7th, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death:
cardiac failure
blown by rupture
blown by rupture
Edema of heart
Other conditions: (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 131h

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 0

Signature Robert G. Harris (M. D. or other) _____
Date signed 12/19/44

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

Mark T. Simon

Licensed Embalmer No. *4174*

P. O. Address *6100 W. Flourens St.*

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.