S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 29 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3617

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2778

1. PLACE OF DEATH:

(a) County St. Louis County

(b) City or town Jefferson Barracks (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Veterans Administration Facility (If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution Adm. Dec. 28, 1944 (Specify whether

In this community unknown years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Omn

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 4416 Laclede Avenue (If rural, give location) 9

(e) Citizen of foreign country? - (Yes or No)

If yes, name country - 0

3. (a) PRINT FULL NAME STEVENS, James E.

3. (b) If veteran, name war World War #1

3. (c) Social Security No. Yes-not rem.

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Mrs. Marie Stevens

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Sept. (Month) 7, (Day) 1897 (Year)

8. AGE: Years 47 Months 4 Days 3 If less than one day ___ hr. ___ min.

9. Birthplace Terre Haute, (City, town, or county) Indiana (State or foreign country)

10. Usual occupation Boiler Maker

11. Industry or business -

FATHER
12. Name Unavailable
13. Birthplace Unavailable (City, town, or county) (State or foreign country) 0

MOTHER
14. Maiden name Unavailable
15. Birthplace Unavailable (City, town, or county) (State or foreign country) 0

16. (a) Informant

(b) Address Clinical Records, VAF, Jeff. Bks., Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 13 1945 (Month) (Day) (Year)

(c) Place: burial or cremation NATIONAL CEMETERY

18. (a) Signature of funeral director Provost Und Co.

(b) Address 3710 N. Grand Blvd

19. (a) JAN 12 1945 (Date received local registrar) (b) E. G. McGauran M.D. (Registrar's signature) Cmd

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 10th, year 1945 hour 7:00 minute A. M.

21. I hereby certify that I attended the deceased from December 28, 1944 to January 10, 1945; that I last saw him alive on January 10, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death BRONCHOPNEUMONIA.	14 days
Due to -	
Due to -	
Other conditions Arteriosclerosis, cerebral and peripheral. (Include pregnancy within 3 months of death)	Unknown

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Major findings:
Of operations No operation.
Of autopsy No 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) no

(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 E. V. EDWARDS, Major, M.C. (M. D. or other) 0

Address Acting Clinical Director Date signed 1/10/45

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(Licensed Embalmer's Statement on Reverse Side)

FEB 10 1945

MAY 22 1945

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 Earl E. Provost

Licensed Embalmer No. 1578

P. O. Address 3710 N. Grand

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.