

FILED MAR 28 1945

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town city of St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7008 Virginia Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town city of St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 7008 Virginia Ave.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME GEORGE W. FRENCH

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Anna E. French 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 8 1872
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 5 If less than one day, hr. _____ min. _____

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Richard French
13. Birthplace Maryland
(City, town, or county) (State or foreign country)
14. Maiden name Marie Cole
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Anna E French
(b) Address 7008 Virginia Ave.

17. (a) burial (b) Date thereof 3-16-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director _____
(b) Address 6322 So. Grand Blvd.

19. (a) MAR 14 1945 (b) J. F. Brescak
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13
year 1945 hour 5:00 minute _____ a. M.
21. I hereby certify that I attended the deceased from March 3, 1945 to March 13, 1945
that I last saw him alive on March 13, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death coronary occlusion
Duration _____

Due to _____
Due to _____

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

Major findings:
Of operations _____
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 E. M. M. M. M. M. (M. D. or other) _____
Address 6849 U. S. U. S. U. Date signed 3/14/45

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.....

Virgil L. Bergman
.....
Licensed Embalmer No. *4518*

P. O. Address.....

St. Louis, Mo.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. J778
Registrar's No. 2282

Registration District No. 318 Primary Registration District No. 1003

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

3. (a) PRINT FULL NAME George W. French
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Feb 8 (Month) (Day) (Year)

8. AGE: Years 73 Months Days If less than one day hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country) mo

10. Usual occupation retired

11. Industry or Business
MOTHER FATHER { 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)

16. (a) Informant..... (b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) JUN 6 1945 (Date received local registration) J. F. Beck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month mar Day 3 year 1945 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....
Other conditions..... (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..... (M. D. or other).....
Address..... Date signed.....

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

TEMPORARY

SUPPLEMENTAL

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

NO. 100-100000-100000

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