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#39782
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 6 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8238

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 2831

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days (Specify whether years, months or days)
In this community unk

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 803 No. 6th St.
(If rural, give location)
(e) Citizen of foreign country? unk. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Sewell

3. (b) If veteran, name war unk

3. (c) Social Security No. unk

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 unk (Month) (Day) (Year)

8. AGE: Years 51 Months — Days — If less than one day hr. min.

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

10. Usual occupation unk

11. Industry or business

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

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

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital #1.

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 3-27-45 (Month) (Day) (Year)
(c) Place: burial or cremation Working to

18. (d) Signature of funeral director W. Ruffin
(b) Address 3809 Ruth

19. (a) MAR 29 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20th year 1945 hour 1:45 minute P. M.

21. I hereby certify that I attended the deceased from 3/10/45, 19, to 3/20/45, 19; that I last saw him alive on 3/20/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Thrombophlebitis of rt. leg veins

Due to

Due to

Other conditions Delirium Tremens
(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. J. Dorn (M. D. or other)
Address 1515 Lafayette Date signed 3/20/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.