

FILED MAY 26 1945
318

Primary Registration District No. **1003**

Registrar's No. **4360**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Deaconess Hospital
(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

3. (a) PRINT FULL NAME Joel H. Counts

8. (b) If veteran, name war Nil 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Rosa Counts 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased May 19 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 11 26 hr. min

9. Birthplace Unknown - Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Counts
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Hazel Johnson
(b) Address River Rouge, Michigan

17. (a) Burial (b) Date thereof 5-18-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place; burial or cremation Flat River, Missouri

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) MAY 16 1945 J. F. Brebeck
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
(c) City or town Flat River
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) _____
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15
year 1945 hour 12 minute NR. M.

21. I hereby certify that I attended the deceased from May 13 45
1945 to May 15 - 45
that I last saw in alive on May 15, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Sept Coronary occlusion

Due to Arterial sclerosis
Chronic atherosclerosis

Due to Heart
Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____
Of autopsy: Yes
Microscopic study

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 John Madison (M. D. or other) _____
Address Flat River, Missouri Date signed 5/15/45

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

00
17
9

94
5
2 NR.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

JUL 19 1948

JUN 5 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.....

Albert G. Hopper

Licensed Embalmer No.

2971

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, above space should be left blank.