

FILED JUN 9 1945 318

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **4794**

1. PLACE OF DEATH:

(a) County Missouri
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5076 Cates Ave.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No 5076 Cates Ave.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles Emery Halladay

3. (b) If veteran, name war _____ 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 Julia 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 27 1870
(Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days I If less than one day _____ hr. _____ min.

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

10. Usual occupation Theatrical Manager

11. Industry or business _____

MOTHER FATHER { 12. Name Albert Halliday
13. Birthplace New York
14. Maiden name Elizabeth Fitzpatrick
15. Birthplace London
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Julia Halladay
(b) Address 5076 Cates Ave.

17. (a) Burial (b) Date thereof 5 31 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Old St. Peters Cem.

18. (a) Signature of funeral director Sullivan Funeral Dir.
(b) Address 2849 No. Euclid Ave.

19. (a) MAY 30 1945 (b) J. F. Bruesch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28th.
year 1945 hour 9 minute 35 P.M.

21. I hereby certify that I attended the deceased from Sept 15th
1944 to 5-28-45
that I last saw him alive on 5-28-45
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

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 Clayce E. Kane (M. D. or other) _____
Address 766 Walton Date sign 5-29-45

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

100
17
9

Dr. Clyde Kane

706 Walton

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 *Robert L. Dunkman*
Licensed Embalmer No. *23553*

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.