#31647

V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19127

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5589-

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
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1mo-21 days (Specify whether years, months or days)

In this community Life

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. 1529a North Union
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME JAMES PRINCE

3. (b) If veteran, name war ---

3. (c) Social Security No. ---

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife infant

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

7. Birth date of deceased March 31st 1945 (Month) (Day) (Year)

8. AGE: Years | Months 3 | Days | If less than one day hr. min.

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

10. Usual occupation nil

11. Industry or business

MOTHER FATHER

12. Name Milburn Prince

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

14. Maiden name Doris Meier

15. Birthplace Unk (City, town, or county) (State or foreign country)

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-28-45 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ City Cemetery

18. (a) Signature of funeral director W. J. White

(b) Address City Hospital No. 1

19. (a) JUN 27 1945 (Date received by local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1st year 1945 hour 1:00 minute A M.

21. I hereby certify that I attended the deceased from 4-11, 1945 to 6-1, 1945 that I last saw him alive on 6-1, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia — Duration 1wk
Staphylococcal sepsis — 2wks

Due to 107

Due to

Other conditions Lung Abscess-rt. L.B. — 1mo.
(Include pregnancy within 3 months of death)
Staphylococcal Abscess of Scalp

Major findings: Of operations Antrotomy — bilateral mastoidectomy

Of autopsy Lung abscess, Bronchopneumonia

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 C. G. Watkins (M. D. or other) M.D.

Address St. Louis City Hosp. #1 Date signed 6-1-45

(Licensed Embalmer's Statement on Reverse Side)

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.