. S. No. 2
DM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22099

FILED AUG 11 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6846

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: St. Louis Children's Hospital
(If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Franklin 999

(c) City or town West Frankfort
(If outside city or town limits, write "RURAL")

(d) Street No. 11 NR.
(If rural, give location)

(e) Citizen of foreign country? 2 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME James, Carol [redacted]

3. (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 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased January (Month) 3 (Day) 1945 (Year)

8. AGE: Years | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace West Frankfort (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Jack James
13. Birthplace Unknown (City, town, or county) England (State or foreign country)

MOTHER
14. Maiden name Mary Whittington
15. Birthplace West Frankfort (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Jack James
(b) Address West Frankfort, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-3-45 (Month) (Day) (Year)
(c) Place: burial or cremation West Frankfort, Ill.

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

19. (a) AUG 3 1945 (Date received local registrar) J. F. Bedell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 1
year 45 hour 9 minute 45 P.M.

21. I hereby certify that I attended the deceased from 7
30, 1945, to 8-1, 1945;
that I last saw him alive on 8-1 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Congenital Heart Disease with decompensation	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

157

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 0

23. Signature Gilbert B. Forbes (M. D. or other)
Address 500 S. Kingshighway Date signed 8-2-45

(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 John Ogorzalek

Licensed Embalmer No. 3398

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.