

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

**FILED** JUL 20 1945  
**318**

**10003**

**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:  
**Missouri Baptist Hospital 0**  
(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 **John J. Mansfield**  
3. (b) If veteran, name war..... **Nil**  
3. (c) Social Security No..... **None**

4. Sex **Male 0** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Single 0**  
6. (b) Name of husband or wife.....  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased **March 1 1867**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**78 4 7** hr. min.

9. Birthplace **St. Louis Missouri 0**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business.....

12. Name **Michael Mansfield**  
13. Birthplace **Unknown Ireland 4**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Margaret Flavin**  
15. Birthplace **Unknown Ireland 4**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Shirley Mengelkamp**  
(b) Address **18 Noland, Kirkwood, Mo.**

17. (a) **Removal** (b) Date thereof **7-9-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Edwardsville, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) **JUL 9 1945 J. J. Predeck**  
(Date received local Registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Illinois** (b) County **Madison 999**  
(c) City or town..... **Edwardsville**  
(If outside city or town limits, write "RURAL")  
(d) Street No..... **113 Benton St.**  
(If rural, give location)  
(e) Citizen of foreign country?..... **2. (Yes or No)**  
If yes, name country.....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **July** day **8**  
year **1945** hour **11:50** minute **A.**  
21. I hereby certify that I attended the deceased from **7-6-45 8:00**  
**7-8-45**, 19, to **7-7-45**, 19,  
that I last saw him alive on **7-7-45**, 19,  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
**Cancer Deception**  
Duration **helpful**  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....  
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)  
(c) Means of injury.....  
23. Signature **Phemie G. Quinn P.** (M.D.)  
Address **1927 1/2 Union** Date signed **7/19/45**

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

00  
17  
9

MOTHER FATHER

**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, fact should be so stated above.**