

No. 2
5-17-39
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FILED OCT 25 1945
318

1003

State File No. _____
Registrar's No. 8991

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis Missouri
(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 - Max C. Starloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 20
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
Street No. 2908 N. 22nd St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME TONG LEONG

3. (b) If veteran, _____ name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Yellow
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife Grace Leong
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased Aug 14 1885
(Month) (Day) (Year)

8. AGE: Years 60 Months 2 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace San Francisco Calif.
(City, town, or county) (State or foreign country)

10. Usual occupation Laundryman

11. Industry or business Laundry

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Lucille Frizzell

(b) Address 2222 Benton St.

17. (a) Burial (b) Date thereof Oct 18 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cem.

18. (a) Signature of funeral director Chas. G. Duff

(b) Address 4457 Washington Blvd.

19. (a) OCT 18 1945 (Date received local registration)
J. J. Buresch (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 16th
year 1945 hour 2:00 minute A. M.

21. I hereby certify that I attended the deceased from 10/7/45
19____ to 10/16/45 19____
that I last saw him alive on 10/16/45 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral of Liver

Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy _____

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 James J. Smith (M. D. or other)
Address 1515 Lafayette Date dictated 10/16/45

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

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.....

Rex E. Campbell

Licensed Embalmer No. *3881*

P. O. Address. *St. Louis, Mo*

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.

Registration District No. 318

Primary Registration District No. 1003

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:

(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 Jung Seung
3. (b) If veteran, name war..... 3. (c) Social Security No. 44-3888

4. Sex m 5. Color or race yellow 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Grace Seung 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased (Month) Aug (Day) 14 (Year) 1925
8. AGE: Years 60 Months Days If less than one day
hr. min.

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

10. Usual occupation

11. Industry or business

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

16. (a) Informant.....
(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) OCT 30 1945 (b) J. F. Bredeek (Registrar's signature)
(Date received for registration)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16 year 1945 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw him..... alive on....., 19..... and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....
Due to.....
Other conditions..... (include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations.....
Of autopsy.....
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..... (M. D. or other).....
Address..... Date signed.....

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

SUPPLEMENTARY

32100