No. 1—2—
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 10 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34662

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2546

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Jefferson Barracks (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 192 days (Specify whether
In this community See above years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ?St. Louis 96
(c) City or town Wellston (If outside city or town limits, write "RURAL")
(d) Street No. 1610 Kienlen Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MAIN, George G.
3. (b) If veteran, name war SPAW
3. (c) Social Security No. 496 14 6767
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Eva Main
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased May (Month) 15 (Day) 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
71	5	17	hr. min.

9. Birthplace Winnebago City (City, town, or county) Minnesota (State or foreign country)
10. Usual occupation Retired Machinist
11. Industry or business --
FATHER 12. Name Hiram Main
13. Birthplace (City, town, or county) Illinois (State or foreign country)
MOTHER 14. Maiden name Amanda Pearce
15. Birthplace (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Clinical Clerk, Vet. Adm. Fac.,
(b) Address Jefferson Barracks, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-45 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) 11-6-45 (Date received local registrar) (b) E. G. McGanan M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 2 year 1945 hour 12:25 minute P. M.
21. I hereby certify that I attended the deceased from April 24, 1945, to November 2, 1945; that I last saw him alive on November 2, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CORONARY ARTERIOSCLEROTIC HEART DISEASE WITH MYOCARDIAL DAMAGE, AURICULAR FIBRILLATION & MYOCARDIAL INSUFFICIENCY.	Unknown
Contributory Cause.	
PLEURISY SUPPURATIVE CHRONIC RT.	Unknown
CEREBRAL ARTERIOSCLEROSIS WITH PSYCHOSIS.	1 Mo
INTERTROCHANTERIC FRACTURE LEFT FEMUR. (Include pregnancy within 3 months of death)	3½ days

Major findings: Of operations Thoracic Surgery Rt. 8/17/45 and 10/17/45
Of autopsy No autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) No
(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 E. V. EDWARDS, Lt. Col., (M. D. or other) M.C., Clinical Director.
Address Vet. Adm. Fac., Jeff. Brks. Mo. Date signed 11/2/45

(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 J. Ogonoski

Licensed Embalmer No. 2398

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.

S. No. 2B
M—5-43
Mo I X36930

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. A 00

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2546

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Jefferson Barracks
(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME George G. Main

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 15 (Day) 1874 (Year)

8. AGE: Years 71 Months 5 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Minn (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day

year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 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)

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) Fracture-accidental

(b) Date of occurrence Oct. 29, 1945

(c) Where did injury occur? Jefferson Barracks, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In hospital (Specify type of place)

While at work No (e) Means of injury Fell in toilet

23. Signature E. V. EDWARDS, Lt. Col. MC (M. D. or other)
Clinical Director

Address Vet. Adm. Hosp., Jeff. Bks., Mo. Date signed 11-20-45

SUPPLEMENTARY

34662