

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
NOV 23 1945
310
STANDARD CERTIFICATE OF DEATH

35436

State File No. _____

FILED NOV 23 1945
Registration District No. 310

Primary Registration District No. 10403

Registrar's No. 9878

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: PEPPER HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 WEEKS
(Specify whether in this community 50 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4518 Page
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years

3. (a) PRINT FULL NAME GEORGE JAMES
3. (b) If veteran, name war WWI
3. (c) Social Security No. _____
4. Sex MALE 5. Color or race COL
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife NONE
6. (c) Age of husband or wife if alive NONE years
7. Birth date of deceased MAY 19 1876
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11/10 day _____
year 45 hour 4 minute _____ P. M.
21. I hereby certify that I attended the deceased from 10/15
_____, 1945, to 11/10, 1945
that I last saw him alive on 11/10
and that death occurred on the date and hour stated above.

8. AGE: Years 69 Months 5 Days 22
If less than one day _____ hr. _____ min.

Immediate cause of death Coronary Thrombosis
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Duration 3 weeks

9. Birthplace BOLIVAR TENN
(City, town, or county) (State or foreign country)
10. Usual occupation LABORER
11. Industry or business R.R. IS.
12. Name ANDREW JAMES
13. Birthplace BOLIVAR TENN
(City, town, or county) (State or foreign country)
14. Maiden name CARRIE LEE BEE
15. Birthplace BOLIVAR TENN
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Carrie McNeal
(b) Address 4518 Page Ave
17. (a) PEPPER (b) Date thereof 11/10/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director Frank H. Kelly
(b) Address 2020 Ball Ave
19. (a) NOV 17 1945 (b) _____
(Date received local registrar) (Registrar's signature)

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) _____ (a) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address 11 N. Jefferson Date signed 11/13

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. Age should be stated in years and months.

NOV 14 1945

(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.....

W. Claude Gordon

Licensed Embalmer No.....

3489

P. O. Address.....

4575 Aldine

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, above space should be left blank.

2B
5-41
27892

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **318**

Primary Registration District No. _____

Registrar's No. **9878**

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: _____
(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 George James

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color of race Col.

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased May 18 1871
(Month) (Day) (Year)

8. AGE: 69 Years 5 Months 22 Days
If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) NOV 27 1945 (b) J. F. Bredbeck
(Date received local registrar) (Registrar's signature)

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 11 day 20
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, 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 _____

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)
(e) Means of injury _____

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

35426