

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **35439**
Registrar's No. **10476**

FILED DEC 12 1945
Registration District No. _____

Primary Registration District No. _____

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

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:
BARNARD SKIN + CANCER HOSP
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 4816^A LABADIE AVE
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Melvin O. Jaques

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

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December 2
year 1945 hour 4 minute 50 A. M.

4. Sex MALE

5. Color of race WHITE

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

6. (b) Name of husband or wife LILLIAN SMITH JAQUES

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

7. Birth date of deceased MARCH 23 1883
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-7-45, 19____, to 12-2-45, 19____.

that I last saw h. in alive on 12-2-45, 19____, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>62</u>	<u>8</u>	<u>9</u>	hr. _____ min. _____

Immediate cause of death WLEMI A

Due to Acute and chronic pyelonephritis

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

10. Usual occupation SALESMAN

Due to Spontaneous carcinoma, bladder

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

11. Industry or business _____

12. Name GARY JAQUES

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

14. Maiden name LAURA WOODS

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

Major findings: AS ABOVE

Of operations SP

Of autopsy AS ABOVE

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant MARION SCHNEDEY

(b) Address 4816^A LABADIE AVE

17. (a) BURIAL (b) Date thereof 12-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director STROOT-CARROLL

(b) Address 4600 NATURAL BRIDGE

19. (a) DEC 3 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) (e) Means of injury _____

23. Signature Helen Reel Getchell (M. D. or other) _____

Address Barnard Skin + Cancer Date signed 12/2/45

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.....

HE Burgess

Licensed Embalmer No. *4029*

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.