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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. **39408**
 Registrar's No. **11308**

FILED JAN 5 1948
 Registration District No. **318**

Primary Registration District No. **1003**

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:
City Hosp.
(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)

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. **4150 W Lee Ave.**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Jules J. LaChance**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Hulda Friedrich LaChance** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **October 12 1872**
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | 73 | 2 | 11 | _____ hr. _____ min. |

9. Birthplace **Duquoin Illinois**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Construction Man**

11. Industry or business
 12. Name **August La Chance**
 13. Birthplace **Unknown**
 14. Maiden name **Edith Price**
 15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hulda LaChance**
 (b) Address **4150 W Lee Ave.**
 17. (a) **Burial** (b) Date thereof **12/26/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Stroot-Carroll**
 (b) Address **4800 Natural Bridge Ave.**
 19. (a) **DEC 24 1945** (b) *J. Friedrich*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **23**
 year **1945** hour **3** minute **35** A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Thrombosis
 Due to _____
 Due to **83 a**
 Other conditions _____
(Include pregnancy within 3 months of death)

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

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 *Fatouk E. Jeylo* (M. D. or other) _____
 Address *Ally St* Date signed *12/24/45*

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.....

Licensed Embalmer No. 4366

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.