

FILED JAN 13 1945

Registrar's No. **11490**

Registration District No. _____

Primary Registration District No. **1003**

1. PLACE OF DEATH

(a) County St. Louis MO
(b) City or town St. Louis MO
(c) Name of hospital or institution City Hosp - 2
(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

REX MC LIN

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male
5. Color of hair Black

6. (a) Single, widowed, married, divorced 1
6. (c) Age of husband or wife if alive abt 1898

6. (b) Name of husband or wife _____

7. Birth date of deceased (Month) (Day) (Year)

8. AGE

Years 47 Months _____ Days _____ If less than one day hr. _____ min. _____

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

St. Louis MO

10. Usual occupation

unk known

11. Industry or business

unk known

12. Name

unk known

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

unk known 9

14. Maiden name

unk known

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

unk known 9

16. (a) Informant

Dr. T. Callahan

(b) Address

300 Clark

17. (a) Anatomical Board (Burial, cremation, or removal)

Date thereof 12-11-45 (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. Patton

(b) Address 8500 Rutland

19. (a) DEC 23 1945 (Date received local registrar)

J. F. Brudek (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26 year 1945 hour 2 minute 15 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 LT M TREMONIA
Due to M. M. A

Other conditions (Include pregnancy within 3 months of death) 1/8

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 Jabros E. J. Co. (M. D. or other) Aly Ken Address _____ Date signed 12/24/45

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.....

Licensed Embalmer No.....

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.