

No. 2
M-5-43
5-17-39
I X36671

FILED FEB 13 1946

Registration District No. **218** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff Memorial
(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 _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **912 A. Angelrodt Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **JOHN LUCAS**
(b) If veteran, name war **Unknown**
(c) Social Security No. **Unknown**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan.** day **31st**
year **1946** hour **5:50** minute **A** M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **August 11 1872**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1-24-46**, 19, to **1/31/46**, 19, that I last saw him alive on **1/31/46**, 19, and that death occurred on the date and hour stated above.

8. AGE: Years **73** Months **5** Days **20**
If less than one day _____ hr. _____ min.

Immediate cause of death **Lymphatic Leukemia**
Due to _____
Due to _____

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **Unknown**

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name **Vincent Lucas**
13. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Anna Unknown**
15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Mrs. Louis Breloski**
(b) Address **912 A. Angelrodt Ave.**
17. (a) **Burial** (b) Date thereof **2-5-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Memorial Park Cem.**

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? _____

18. (a) Signature of funeral director **Albert H. Hoppe Inc.**
(b) Address **4700 Washington Blvd.**
19. (a) **FEB 5 1946** **J. F. Breder**
(Date received local registrar) (Registrar's signature)

23. Signature **James J. Stout** 1515 Lafayette 2/4/46
While at work? _____ (Specify type of place) (e) Means of injury _____
Date signed _____

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

2801

NO EMBALM

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.