

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7346

FILED MAR 6 1946
318

State File No. 1815
Registrar's No.

Registration District No. Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County.....
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexian Brothers Hospital
(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 Joseph J. Cummings
3. (b) If veteran, name war None 3. (c) Social Security No. _____

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 Single years
7. Birth date of deceased. March 12, 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 11 10 hr. min.

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

10. Usual occupation unknown

11. Industry or business.....

MOTHER FATHER
12. Name James Cummings
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Mary Cummings
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Patrick M. Cummings
(b) Address 6414 Alabama

17. (a) Burial (b) Date thereof 25 Feb. 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation N. Olive Cemetery

18. (a) Signature of funeral director Southern Funeral Home
(b) Address 832 S. Grand Blvd.

19. (a) FEB 24 1946 (b) J. P. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 0-0-0
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 1-7
(d) Street No. 6414 Alabama (If rural, give location) 9
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 22nd
year 1946 hour 5 minute 20 p.m.

21. I hereby certify that I attended the deceased from Dec 27, 1945 to Feb 22, 1946
that I last saw him alive on Feb 22, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration
Due to 51
Due to.....

Other conditions Carcinoma of testis
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of testis
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?

(Specify type of place)
While at work?..... Means of injury.....

23. Signature J. Moore Peterson (M. D. or other) J. D.
Address 719 Frisco Bldg Date signed 2-27-46

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

Dr. Powell
Francis
729

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. 3653

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.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(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 Joseph J. Cummings
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased. Mar 12 (Month) 1946 (Day) 1946 (Year)

8. AGE: Years 64 Months 4 Days 2 If less than one day..... hr. 7 min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) (Date received local registrar) (b) J. F. Bredett (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 Mar Day 22 Year 1946 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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.....

Duration

Due to.....

Due to.....

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

PHYSICIAN

Major findings: Of operations.....

Of autopsy.....

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.....

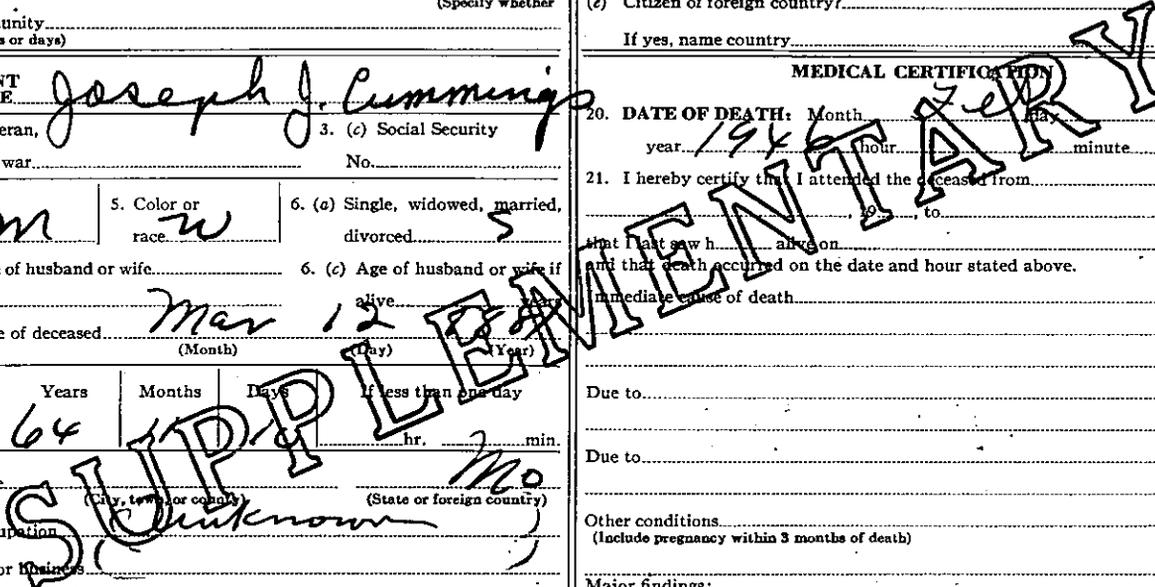
(c) Where did injury occur?..... (City or town) (County) (State)

(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.....



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

MAR 13 1946

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