

FILED DEC 31 1947

318

Primary Registration District No. 1003

Registrar's No. 11604

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: Jewish Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution..... 7 Weeks
 (Specify whether
 In this community..... Yes
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... of Missouri (b) County..... oao
 (c) City or town..... St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No..... 20a South 8th Street,
-25- (If rural, give location)
 (e) Citizen of foreign country?..... XXX No)
 If yes, name country.....

3. (a) PRINT FULL NAME..... Joe Lin
 (b) If veteran, name war..... No
 3. (c) Social Security No.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month..... 12 day..... 13
 year..... 1947 hour..... 30 minutes..... P.M.

4. Sex..... Male 5. Color or race..... Chinese
 6. (a) Single, widowed, married, divorced..... Married
 6. (b) Name of husband or wife..... Mabel Lin
 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased..... Unknown
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from..... 10/12 1947 to..... 12/13 1947;
 that I last saw him..... alive on..... 12/12 1947;
 and that death occurred on the date and hour stated above. Duration

8. AGE: Years..... abt - 66 Months..... ~ Days..... ~ If less than one day
 hr..... min.....

Immediate cause of death..... Brain tumor, left temporal 2 cm,
 Due to..... 54
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

9. Birthplace..... California
 (City, town, or county) (State or foreign country)
 10. Usual occupation..... Restaurant Owner

Major findings: glioblastoma
 Of operations.....
 Of autopsy.....
 PHYSICIAN
 Underline the cause of which death should be charged statistically.

11. Industry or business..... Business
 12. Name..... Unknown
 13. Birthplace..... Unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name..... Unknown
 15. Birthplace..... Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant..... Joe Jone
 (b) Address..... No. 10 South 8th Street,
 17. (a) Burial (b) Date thereof..... 12-22-47
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation..... Valhalla Cemetery

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)

18. (a) Signature of funeral director..... John P. Collins & Brow
 (b) Address..... 928 N. Grand Blvd
 19. (a) DEC 20 1947 (b) J. F. Bredel
 (Date received local registrar) (Registrar's signature)

Signature..... Arthur Williams (M. D. or other) Med
 Address..... 634 W. Grand Date signed..... 12/15/47

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

MOTHER FATHER

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.....

J. Allen Davis Jr.

Licensed Embalmer No. *4053*

P. O. Address *St. Louis*

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.