

No. 2  
1/47  
17-39

State File No.

Registrar's No.

FILED FEB 9 1948

Registration District No. **318**

Primary Registration District No. **1003**

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

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:  
St. Louis City Hospital—Max C. Starkloff  
(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 Mo. (b) County.....

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 5017 Rosa Ave.  
Memorial (If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME JAMES B. HART

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

4. Sex M. Color or race W.

5. (a) Single, widowed, married, divorced W.

6. (b) Name of husband or wife Gussie Hart

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

7. Birth date of deceased Oct. 4th., 1867  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
80	3	20	..... hr. .... min.

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

10. Usual occupation Clerk

11. Industry or business A. J. Donnelly Undt. Co.

12. Name Henry Hart Pa. /

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

14. Maiden name Margaret O'Neill

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

16. (a) Informant Mrs. Arthur L. Deyen

(b) Address 5017 Rosa Ave.

17. (a) Burial Memorial Park  
(Burial, cremation, or removal) (b) Date thereof 1-27-48  
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Arthur J. Donnelly  
3840 Lindell Blvd.

(b) Address.....

19. (a) Jan 26 1948 (b) Registrar's signature J. F. Brown  
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24th  
year 1948 hour 11 minute 15 A. M.

21. I hereby certify that I attended the deceased from 1/15/48  
....., 19....., to Jan 24th, 19 48  
that I last saw him alive on Jan 24th, 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Arteriosclerosis  
Excep halapathy

Due to.....

Due to.....

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

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?.....  
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature J. Loury Brown, M.D. (M. D. or other)  
Address 1515 Lafayette Date signed 1/26/48

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

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**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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette -

**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.