

STANDARD CERTIFICATE OF DEATH

State File No. **21413**
Registrar's No. **6049**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County City St. Louis
(b) City or town City St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Infirmary Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5-24-45/7-7-48
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Abraham Tudor.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Seperate

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

7. Birth date of deceased 2 - 8 - 1861
(Month) (Day) (Year)

8. AGE: Years 87 Months 4 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation ?

11. Industry or business _____

12. Name Jacob Tudor.

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

14. Maiden name Alice

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

16. (a) Informant City Infirmary Records

(b) Address 5800 Arsenal St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-1948 (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Burial Park

18. (a) Signature of funeral director Weick Bro. Und. Co.

(b) Address 2201 S. Grand Bl.

19. (a) JUL 9 1948 (Date received local registration) (b) J. F. Bredenk (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 100
(c) City or town City St. Louis. 17
(If outside city or town limits, write "RURAL") 9
(d) Street No. 5800 Arsenal St. 0
(If rural, give location) 13
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 7
year 19 48 hour 3:20 minute 20a. a.m.

21. I hereby certify that I attended the deceased from 5
1, 19 48, 7-7-, 19 48
that I last saw him alive on 7 - 7, 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Head of Pancreas Duration 1 yr.

Due to Htg

Other conditions Metastasis to Liver & Aortic Lymph nodes

Major findings: Of operations _____ Of autopsy Same PHYSICIAN _____

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? _____ (b) Means of injury _____

23. Signature Mario Oberto M.D. (M. D. or other) _____
Address 3903 5800 Arsenal Date signed 9/7/48

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

MOTHER FATHER

mil.

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 *Othman's 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.