

FILED NOV 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38654
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2584

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Hillsdale</u>		c. CITY OR TOWN <u>Hillsdale</u> <u>4/6/0</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>2157 Rosebud Ave.</u>		d. STREET ADDRESS (If outside, give location) <u>2157 Rosebud Ave.</u>	
Length of stay in 1b <u>15 Yrs.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>BERNARD</u> Last <u>JAMES</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>19,</u> Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8, 1887</u>
9. AGE (In years last birthday) <u>70</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employee</u>	11. BIRTHPLACE (City and state or country) <u>Krebs, Okla.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Century Elec. Co.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Marion James</u>		13b. MOTHER'S MAIDEN NAME <u>Rose Sentimi</u>	14. NAME OF HUSBAND OR WIFE <u>Bessie James</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War #1</u>		16. SOCIAL SECURITY NO. <u>489-07-2463</u>	17. INFORMANT <u>Beverly M. Indecar</u> Address <u>Collinsville, Ill. 127 W. Juda</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unknown natural causes</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unk</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>7954</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Herbert R. Domke</u> <u>Herbert R. Domke, MD, local registrar</u>		22b. ADDRESS <u>651 S. Brentwood, Clayton, Mo.</u>	22c. DATE SIGNED <u>10/28/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>10-23-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	23d. LOCATION (City, town, or county) (State) <u>Collinsville, Ill.</u>
24. FUNERAL DIRECTOR <u>Paul E. Froman</u>	25. DATE RECD. BY LOCAL REG. <u>10-21-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Domke</u>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

are

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Paul E. Froman*

Licensed Embalmer No. *7808 IL*

P. O. Address *COLLINSVILLE*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.