

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8802** STATE FILE NUMBER

STATE AMENDED  
2  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF  
ITEM NO.

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |  | Length of stay in 1b  | c. CITY OR TOWN <b>St. Louis</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>403a Blase</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>403<sup>1/2</sup> Blase</b>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>George B. Julian</b> Middle <b>a/k/a/George F. Julian</b> Last  |  |   | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>20th</b> , Year <b>1961</b>  |  |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/20/1900</b>   | 9. AGE (last birthday)<br><b>61</b>  | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HR<br>Hours Min.                        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>boxmaker retired</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>Paris, Ill</b>  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |   |
| 13a. FATHER'S NAME<br><b>William Julian</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Margaret Joan Ryan</b>  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Elsie Julian</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>yes (6417666)</b>   |  |   | 17. INFORMANT<br>Address<br><b>Elsie Julian, 403a Blase</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b>                                    |
| IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis, et.</b>   |  |   |  |  |   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b>  |  |   |  |  |   |
| DUE TO (c) <b>332XH</b>   |  |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Adenocarcinoma of Stomach - Surgery Dec. 1957</b>   |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>Month, Day, Year   | 20d. INJURY OCCURRED WHILE AT WORK <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 <b>8-29-52</b> to <b>9-20-61</b> and last saw <sup>her</sup> him alive on <b>9-9-61</b><br>Death occurred at <b>7:25 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |   |
| 22a. SIGNATURE (Degree or title)<br><b>Norman G. Jones, M.D.</b>  |  |   | 22b. ADDRESS<br><b>8321 N. Broadway (151)</b>  |  | 22c. DATE SIGNED<br><b>9-22-61</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>   | 23b. DATE<br><b>9/23/61</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake Charles Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Co., Mo.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>DIEDRICH FUNERAL HOME, 8319 Hallsferry</b>   |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>SEP 22 1961</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Roan Smith, M.D.</b>   |   |

**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 Harry E. Monroe

Licensed Embalmer No. 4495

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.