

791

1003

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis Mo  
(b) City or town St. Louis  
(c) Name of hospital or institution City Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis  
(c) City or town St. Louis 1725  
(If outside city or town limits, write "RURAL")  
(d) Street No. 114 N. Bluffway  
(If rural give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Joseph Choan

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

4. Sex M 5. Color of hair B 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased Feb 23 1889  
(Month) (Day) (Year)

8. AGE: Years 52 Months 3 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Teacher

11. Industry or business \_\_\_\_\_

12. Name William Choan

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

14. Marital status Married

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

16. (a) Informant Dr. Choan

(b) Address 114 N. Bluffway

17. (a) Burial (b) Date thereof 6-21-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director William Choan

(b) Address 2849 N. Euclid

19. (a) JUN 21 1941 (b) J. W. Brudick  
(City or town) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19  
year 1941 hour 4:30 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations 23  
Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_

23. Signature Alfred Perry (M. D. or other)  
Address 114 N. Bluffway Date signed 6/21/41

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

30  
179

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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..... *Al. Mayfield*  
Licensed Embalmer No..... *3077*  
P. O. Address.....

**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.**