

No. 2  
-1-4-41  
5-17-39  
I X28390

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
BARNES HOSPITAL  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution 3 days (Specify whether \_\_\_\_\_)  
In this community 7 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County \_\_\_\_\_  
(c) City or town West Frankfort  
(If outside city or town limits, write "RURAL")  
(d) Street No. 106 E 4th (If rural, give location) A.R.  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 2

3. (a) PRINT FULL NAME ROLINITIS, CHARLES, J.

3. (b) If veteran, name war Unk  
3. (c) Social Security None

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Divorced  
6. (b) Name of husband or wife Unknown  
6. (c) Age of husband or wife if alive unk years  
7. Birth date of deceased Feb 11 1892  
(Month) (Day) (Year)

8. AGE: Years 59 Months 5 Days 28  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Coal Miner

11. Industry or business Industry

12. Name Stanley Rolinitis  
13. Birthplace Europe (City, town, or county) (State or foreign country) X  
14. Maiden name Unknown  
15. Birthplace Europe (City, town, or county) (State or foreign country) X

16. (a) Informant John Rolinitis  
(b) Address Lowell Mich

17. (a) removal (b) Date thereof 8-10-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Central Unit

18. (a) Signature of funeral director Case Ave  
(b) Address Case Ave

19. (a) AUG 10 1941 (b) G. F. Credick  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 8  
year 1941 hour 2 minute 25 P.M.

21. I hereby certify that I attended the deceased from Aug 2 1941 to Aug 8 1941  
that I last saw him alive on Aug 8 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure  
Due to Arteriosclerotic Heart disease

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy cirrhosis of liver

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) (e) Means of injury \_\_\_\_\_

23. Signature H. Bradley (M. D. or other) \_\_\_\_\_  
Address BARNES HOSPITAL Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
28.3479-01-8567

**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 *Alford G. Burdy*  
Licensed Embalmer No. *4202*

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.**