

JAN 24 1942 7911
Registration District No. 7911

Primary Registration District No. 1003

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:
5365 Maple Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 3 yrs. years, months or days)

3. (a) PRINT FULL NAME James Joseph Devereux

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Ann 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased June 12th. 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 6 18 hr. min.

9. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Superintendent

11. Industry or business Federal Barge Lines

12. Name James Devereux

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

14. Maiden name Catherine Delano

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

16. (a) Informant Mrs Ann Devereux

(b) Address 5365 Maple Ave.

17. (a) Burial (b) Date thereof 1/2/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cent

18. (a) Signature of informant Harrison & Sheahan Und Co

(b) Address 4415 Washington Blvd.

19. (a) DEC 31 1941 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 5 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL") 9
(d) Street No. 5365 Maple Ave.
(If rural, give location)
(e) Attending Physician (Yes or No)
Physician's name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30th.
year 1942 hour 6:45 PM minute _____ 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 Chronic Myocarditis
Chronic Parenchymatous
Nephritis
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 131

Major findings:
Of operations _____
Of autopsy _____

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 Thomas F. Callahan (Seal or other)
Address 10111 Date signed 2-2-42

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Homer N. Brutz*

Licensed Embalmer No. *3882*

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.