

FILED DEC 9 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10291

1. PLACE OF DEATH:

(a) County ST. LOUIS MO
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
EA ROUTE CITY HOSP #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____
(c) City or town ST. LOUIS 25
(If outside city or town limits, write "RURAL")
(d) Street No. 1511 FRANKLIN AVE MO
(If rural, give location) 17
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME TONY LESARE

3. (b) If veteran, name war UNKNOWN 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced 9

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

7. Birth date of deceased _____ (Month) (Day) (Year)

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

9. Birthplace FRANCE (City, town, or county) (State or foreign country) 5

10. Usual occupation NONE

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country) 9

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country) 9

16. (a) Informant ANNA HODGE

(b) Address 1511 FRANKLIN

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year) 11-22-43

(c) Place: burial or cremation Autemine Park

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) NOV 30 1943 (Date received local registrar) J. F. Branch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 8 year 1943 hour 7 minute 45 P.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 _____

Due to LOBAR PNEUMONIA

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 108

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)

Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (c) Means of injury 3

23. Signature Thomas J. Callahan (M. D. or other) 3

Address Deputy Coroner Date signed 11-22-43

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.....

Licensed Embalmer No.....

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.