

Registration District No. 318

Primary Registration District 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:
St. Louis Isolation Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2-3-1944 to
2-5-1944. (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County
(c) City or town Collinsville
(If outside city or town limits, write "RURAL")
(d) Street No 209 Juda Avenue.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JOSEPH ESICAR

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: April 7 191
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
29 9 28 hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name Joseph Esicar
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
ELLA WALKER
14. Maiden name
Illinois
15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant Edith V. Minor
(b) Address 5600 Arsenal Street.

17. (a) removal (b) Date thereof FEB 6 - 44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Collinsville, Ill.

18. (a) Signature of funeral director Herbert P. Hesch
(b) Address Collinsville, Ill.

19. (a) FEB 8 1944 (b) J. F. Bradeck
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 5
year 1944 hour 7 minute 15P M.

21. I hereby certify that I attended the deceased from 2-3-1944
to 2-5-1944, 19____, to _____, 19____;
that I last saw him alive on February 5, 1944;
and that death occurred on the date and hour stated above.
Immediate cause of death Purulent meningitis Duration _____

Due to pneumococcus?
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy as given above

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 Dr. Max well (M. D. or other) _____
Address 5600 Arsenal Date signed 2-6-44

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

1238
802T
1238
802T

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.....

Not Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed *Herbert A. Kasse*.....

Licensed Embalmer No. *2803*.....

P. O. Address: *Collinsville, Ill*.....

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.