

FILED FEB 28 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1483

1. PLACE OF DEATH:

(a) County No County
(b) City or town Saint 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 or location)
(d) Length of stay: In hospital or institution Six (6) Days
In this community Eleven (11) Months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State New York (b) County Unknown
(c) City or town Franklinville
(If outside city or town limits, write "RURAL")
(d) Street No. 19 Empire Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: - - - 2

3. (a) PRINT FULL NAME ROBERT T WHALEY

3. (b) If veteran, name war World War II 3. (c) Social Security No. Unknown

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 March 8 1923
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
20 11 5 - - hr. - - min.

9. Birthplace Franklinville New York
(City, town, or county) (State or foreign country)

10. Usual occupation Soldier (Private)

11. Industry or business United States Army

MOTHER FATHER { 12. Name Edwin E Whaley
13. Birthplace Unknown
14. Maiden name Elizabeth (Last name unknown)
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Service and Clinical Records
(b) Address Sta Hosp, Jefferson Bks, Mo.

17. (a) Personal (b) Date thereof 2-15-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Franklinville N.Y.

18. (c) Signature of funeral director Josiah Albright
(b) Address Franklinville, Mo.

19. (a) FEB 15 1944 (b) J. F. Brueck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day Thirteenth
year 1944 hour 3:50 minute P M.

21. I hereby certify that I attended the deceased from February 4 1944 to February 13 1944;
that I last saw him alive on February 13 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage, sub-cortical, left frontal lobe Duration _____

Due to Aneurism, congenital

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

Major findings: _____
Of operations: _____
Of autopsy: Confirmed 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? _____

(Specify type of place) _____
(Specify means of injury) _____
23. Signature William G Bernhart (M. D. or other) MD
Address Sta Hosp, Jefferson Bks, Mo Date signed Feb 14 1944

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

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 Felix Armand
Licensed Embalmer No. 3034
P. O. Address Kirkwood Mo

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.