

3. No. 2  
M--2.43  
5-17-39  
X35599

LED MAR 27 1944

318

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

Registrar's No. 2604

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 3017a N. 20th. St. /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 48 years  
(Specify whether years, months or days)

In this community 48 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis 720  
(If outside city or town limits, write "RURAL")

(d) Street No. 3017a N. 20th. St.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Joseph Du Bray

3. (b) If veteran, name war none

3. (c) Social Security No. 488-09-1628

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month march day 17th.  
year 1944 hour 2:15 PM minute \_\_\_\_\_ M.

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Emma Du Bray

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased Dec. 9 1895  
(Month) (Day) (Year)

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.

8. AGE: Years 48 Months 3 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Arterio Sclerosis  
Cardiac Hypertrophy

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation Carrepair Man

11. Industry or business Terminal R. R.

Other conditions 92  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER { 12. Name John Du Bray

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

14. Maiden name Salena Creeley

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

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? \_\_\_\_\_

16. (a) Informant Mrs. Emma Du Bray

(b) Address 3017a N. 20th. St.

17. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Hy. Leidner U. Co.

(b) Address 2223 St. Louis Ave.

19. (a) MAR 18 1944 J. F. Bredeek  
(Date received local registry) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury 3

23. Signature Thomas J. Callahan (M. D. or other)  
Address Deputy Coroner Date signed 3/19/44

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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 John P. Buchholz

Licensed Embalmer No. 1674

P. O. Address 4223 St. Louis

**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.**