

DEED MAY 29 1944

Registration District No. 371

Primary Registration District No. 3066

Registrar's No. 1144

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Marine Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Hours
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Co. Co.

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

(d) Street No. 3903a Botanical
(If rural, give location)

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

3. (a) PRINT FULL NAME James Angus

3. (b) If veteran, name war No

3. (c) Social Security No. 499-26-3023

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19 year 1944 hour 11:45 minute 45 A. 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 Natural causes.

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Dorothy

6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased: April 16 1896
(Month) (Day) (Year)

Due to Cerebral hemorrhage.

Due to Arteriosclerosis.

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

8. AGE: Years 48 Months 1 Days 3 If less than one day _____ hr. _____ min.

Major findings:
Of operations _____

Of autopsy Yes.

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

10. Usual occupation Chauffeur

11. Industry or business Post-Office

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name James Angus

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

{ 14. Maiden name Margaret Casey

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

16. (a) Informant Dorothy Angus

(b) Address 3903a Botanical

17. (a) Burial (b) Date thereof 5-22-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

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? _____

18. (a) Signature of funeral director Howard and Sons

(b) Address 4212 St. Louis Ave.

19. (a) MAY 22 1944 (b) E. J. Moore
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury 3

23. Signature Harold J. Fisher M. Coroner

Address Clayton, Mo. 5-20-44 Date signed _____

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

16
4
3

APR 1 1944

OCT 15 1945

MAY 29 1944

MAY 30 1944
MAY 20 1945

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 Gonsch

Licensed Embalmer No.

3398

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.