

FILED SEP 9 1944
128
Registration District No. _____

Primary Registration District No. 2.000

Registrar's No. 669

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

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
O'Reilly General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 32 days
In this community 32 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3018 Magnolia Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 16
year 1944 hour 3 minute 30 A. M.

21. I hereby certify that I attended the deceased from 16 July 1944 to 16 August 1944;
that I last saw him alive on 16 August 1944;
and that death occurred on the date and hour stated above.
Immediate cause of death Sarcoma, retro-
peritoneal, cause undetermined.
Duration 6 mos.

Due to _____
Due to H6h
Other conditions Hydronephrosis, bilateral 3 mcs.
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy Confirmation of above
diagnoses.

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)
While at work? _____ (e) Means of injury 0
23. Signature H. Cavants (M. D. or other)
Address O'Reilly, St. Louis, Mo. Date signed 8/17/44

3. (a) PRINT FULL NAME JAMES JOSEPH BENA

3. (b) If veteran, name war World War II 3. (c) Social Security No. NONE

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced, Single

6. (b) Name of husband or wife NONE 6. (c) Age of husband or wife if alive NONE years

7. Birth date of deceased August 17, 1924
(Month) (Day) (Year)

8. AGE: Years 19 Months 11 Days 29
If less than one day hr. _____ min. _____

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

10. Usual occupation Student

11. Industry or business College

12. Name Michael Bena

13. Birthplace W.N.H. Austria
(City, town, or county) (State or foreign country)

14. Maiden name Agnes Ballin

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

16. (a) Informant Mrs. Agnes Bena

(b) Address 3018 Magnolia Ave., St. Louis, Mo.

17. (a) Removal (b) Date thereof Aug. 18, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Missouri

18. (a) Signature of funeral director Norman Rohmeyer 710
(b) Address Springfield, Mo.

19. (a) 8-18-44 (b) H. Cavants
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

A report submitted to the Bureau of the Census.

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

Walter E Hamilton

Licensed Embalmer No.

3808

P. O. Address

Springfield, 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.

X