

FILED JAN 15 1945

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11051**

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

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:
City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis, **23**
(If outside city or town limits, write "RURAL")
(d) Street No. 1023 Allen Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Casper Christman

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

4. Sex Male 5. Color or race Wht. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Versa Christman 6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased Aug. 27, 1900
(Month) (Day) (Year)

8. AGE: Years 44 Months 3 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Tailor

11. Industry or business _____

12. Name Joseph Christman

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

14. Maiden name Margaret Hodgkins

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

16. (a) Informant Versa Christman

(b) Address 1023 Allenn Ave.

17. (a) Burial (b) Date thereof 12/26/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sun Set Park

18. (a) Signature of funeral director Wm B. Moydell

(b) Address 1926 Allen Ave.

19. (a) DEC 26 1944 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22
year 1944 hour 10 minute A M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death subarachnoid hemorrhage

of brain suffered when decedent

fell from flight of stairs at

1023 Allen Ave on or about

Dec 9th 1944 Exact time unknown

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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) Accident

(b) Date of occurrence Dec 9th 1944

(c) Where did injury occur? at home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

(Specify type of place) (e) Means of injury as above

23. Signature: Thomas F. Pallan (M. D. or other) _____

Address Carone Date signed _____

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 me

, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Wm. L. Moydell

Licensed Embalmer No. 14267

P. O. Address 1926 Allen

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.