

FILED JAN 22 1945

318

Primary Registration District No.

1003

Registrar's No.

102

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:  
BARNES HOSPITAL  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 days  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME GEORGE NAKAI  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 4. Color or race Yellow  
 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 Unknown  
(Month) (Day) (Year)

8. AGE	Years	Months	Days	If less than one day
<u>abt</u>	<u>60</u>	<u>—</u>	<u>—</u>	hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business Pigmeat Restaurant

MOTHER FATHER {  
 12. Name Unknown  
 13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Tanaka  
 (b) Address 2628 Market St.

17. (a) Cremation (b) Date thereof 1/6/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Edith E. Ambruster

(b) Address 4234 Manchester

19. (a) JAN 9 1945 (b) J. F. Braddock  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2628 Market St.  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2  
 year 1945 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from Dec. 30, 1944, to Jan. 2, 1945;  
 that I last saw him alive on Jan. 2, 1945;  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Respiratory failure  
pneumonia lobax 4 days  
(tularemic)  
 Due to Tularemia 2 wks

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

Of autopsy Disseminated lesions of tularemia

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?

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

23. Signature F. R. Bradley (M. D. examiner)  
 Address BARNES HOSPITAL Date signed 1/3/45

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

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**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..... *Henry Coyne*.....

Licensed Embalmer No. *1284*

P. O. Address..... *St. Louis 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 611

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 162

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(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)

3. (a) PRINT FULL NAME George Nakai  
3. (b) If veteran, name war.....  
3. (c) Social Security No. ....

4. Sex m  
5. Color White  
6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife John  
6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased unk  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day..... min.  
all-60

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....  
(b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof.....  
(Month) (Day) (Year)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....

19. (a) MAR 30 1945  
(Date received local registrar) Registrar's signature J. J. Bredak

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19  
year 1945 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....  
that I last saw him..... alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

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).....

(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?

While at work?..... (Specify type of place)  
(e) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

SUPPLEMENTARY

WALLIE FLAINLI--USE UNFADING BLACK INK--WRITE A LEGIBLE NAME

