

FILED SEP 22 1945

State File No. _____

Registration District No. 317

Primary Registration District No. 3064

Registrar's No. 2229

1. PLACE OF DEATH:

(a) County ST Louis
(b) City or town Ferguson Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Berkley Drive #10 1
(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 MO (b) County 96
(c) City or town FERGUSON 6
(If outside city or town limits, write "RURAL")
(d) Street No. BERKLEY DRIVE #10 2
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Joseph J. Danis Jr

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased May 30 1929
(Month) (Day) (Year)

8. AGE: Years 16 Months 4 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Joseph Danis Sr

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

14. Maiden name Stella Abramczyk

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

16. (a) Informant Father
(b) Address Berkley Drive

17. (a) Burial (b) Date thereof 9-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Central Mort Co
(b) Address 1841 Cass Ave

19. (a) 9-18-45 (b) E. M. Jarman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15th
year 1945 hour 5 minute 30 p. 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 Broken neck and complete transverse fractures of both arms & both legs

Due to Accident

Due to (Struck by train, while a pedestrian)

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

Major findings:

Of operations _____

Of autopsy No

Duration

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 96
(b) Date of occurrence 9-15-45

(c) Where did injury occur? Ferguson St. Louis Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

On private R/R Wabash R.R.
(Specify type of place)
While at work? No (e) Means of injury Blunt Imp.

23. Signature Ernest J. Willman Coroner
(M. D. or other)

Address Clayton Mo Date signed 9-17-45

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

MOTHER FATHER

6
6
2

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

G. W. Wilkinson

Licensed Embalmer No. *3575*

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.