

S. No. 2
OM-5-43
V. 5-17-39
I X36871

FILED NOV 7 1946
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1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **St. Louis**

(c) Name of hospital or institution: **812 N. 13th St.**

(d) Length of stay: In hospital or institution **5 yrs**

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **ST. LOUIS**

(c) City or town **ST. LOUIS**

(d) Street No. **812 N. 13th St**

(e) Citizen of foreign country? **No**

If yes, name country _____

3. (a) PRINT FULL NAME **RAYMOND. REVEIS**

3. (b) If veteran, name war _____

3. (c) Social Security No. **331-16-4629**

4. Sex **Male** 5. Color of race **Col**

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

6. (b) Name of husband or wife **Ellis**

6. (c) Age of husband or wife if alive **1994** years

7. Birth date of deceased **3 27 1901**

8. AGE: Years **32** Months **6** Days **25**

9. Birthplace **Cairo Ills**

10. Usual occupation **Machine Operator**

11. Industry or business _____

12. Name **U. N. K. N. O. W. N.**

13. Birthplace **Ill**

14. Maiden name **Ellis**

15. Birthplace **Ill**

16. (a) Informant **Ellis Reveis**

(b) Address **812 N. 13th St**

17. (a) **Burial** (b) Date thereof **10-26-46**

(c) Place: burial or cremation **FATHER DICKSON**

18. (a) Signature of funeral director **Bernard**

(b) Address **310 3rd St**

19. (a) **OCT 25 1946** (b) **J. J. ...**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **22** year **1946** hour **9** minute **9** 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 **Abcess of right lung**

Due to **Miliary**

Due to **Empyema (Right)**

Other conditions (Include pregnancy within 3 months of death) **110**

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

(e) Means of injury _____

23. Signatur **Thomas J. ...**

Address _____ Date signed **10-24-46**

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

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

JAN 17 1957

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.....

H. Claude Gordon

Licensed Embalmer No. *3489*

P. O. Address *45-75 Aldine*

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.