

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

FILED OCT 23 1948 **318**
Registration District No. _____

Primary Registration District No. **1903**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital—Max C. Starkloff
(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
(If outside city or town limits, write "RURAL")
(d) Street No. 5423 Arsenal St.
Memorial (If rural, give location)
(e) Citizen of foreign country? 13 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JAMES MUIR

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

4. Sex Male 5. Color or race White 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 May 27 1894
(Month) (Day) (Year)

8. AGE: Years 54 Months 4 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace St. Clair Co. Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Bartender

11. Industry or business _____

12. Name William Muir

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

14. Maiden name Ella Million

15. Birthplace St. Clair Co. Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Ella Giles

(b) Address 5423 Arsenal St.

17. (a) Burial (b) Date thereof 10-15-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Episcopate

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) OCT 14 1948 (b) J. B. Lasater
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12th
year 1948 hour 3 minute 45 AM
9/28/48

21. I hereby certify that I attended the deceased from Oct. 12th, 1948, to Oct. 12th, 1948
that I last saw him alive on Oct. 12th, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage of rupture. Duration _____

Due to _____
Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Large cerebral artery of rupture. **PHYSICIAN** _____
Of operations _____
Of autopsy Impairment of cerebral circulation of large artery.
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 James M. ... 1515 Lafayette 10/13/48
(City or town) (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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Jay W. Wilkinson*.....

Licensed Embalmer No..... *3575*.....

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.