

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

23841

Do not use this space.

REC'D AUG 12 1936

791  
1003

Registered No. 6535

1. PLACE OF DEATH

(a) County.....  
(b) Township.....  
(c) City ST. LOUIS (d) Street No. 4447 GREER AVE. St. (If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 4447 Greer Ave St. 10 (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

SAMUEL C. HOUSE

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF KATHERINE E. HOUSE  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JAN. 25, 1850  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 88 5 26

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. STATIONERY  
9. Industry or business in which work was done, as saw mill, bank, etc. ENGINEER  
10. Date deceased last worked at this occupation (month and year).....  
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MARYLAND

13. NAME WILLIAM R. HOUSE

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MARYLAND

15. MAIDEN NAME MARIA NORRIS

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MARYLAND

17. INFORMANT KATHERINE E. HOUSE (ADDRESS) 4447 GREER AVE.

18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY CEMT. DATE 8-25-38

19. FUNERAL DIRECTOR (NAME) ARTHUR J. DONNELLY (ADDRESS) 3840 LINDELL BLVD.

20. FILED Aug 22 1936 J. P. Bredek Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/21/38, 19

22. I HEREBY CERTIFY, That I attended deceased from 10/1/37, 19, to 7/21/38, 19.

I last saw him alive on 7/20/38, 19. Death is said to have occurred on the date stated above, at 1252 m.  
The principal cause of death and related causes of importance were as follows:

Arterio-sclerosis

*GA*

Other contributory causes of importance:

Scurvy

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify no  
(Signed) W. H. Brubaker, M. D.

(Address) 4743 Calverton

**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

*Alfred J. Boedeker*

Licensed Embalmer No.

*2663*

P. O. Address

*4204 Paine*

**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, above space should be left blank.**