

No. 2  
1-10-39  
17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

17097

State File No.

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 4575

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:  
2616 Glasgow 2  
(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)

8. (a) PRINT FULL NAME James T. Howard 630

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. 491-14-8319

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Ada 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased April 18 1868  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 1 4 hr. \_\_\_\_\_ min.

9. Birthplace Howard County, Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Dept. Mgr. Missouri Athletic C.

11. Industry or business \_\_\_\_\_

12. Name Ben Howard 0

18. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Ada Howard

(b) Address 2616 Glasgow

17. (a) Cremation (b) Date thereof 5/25/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cape Girardeau

18. (a) Signature of funeral director [Signature]  
(b) Address 6633 Clayton at Concordia

19. (a) MAY 24 1940 (b) [Signature]  
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis 20  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2616 Glasgow  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22  
year 1940 hour 11 minute 15 P. M.

21. I hereby certify that I attended the deceased from Mar 2nd 1940  
1940 to May 22 - 1940  
that I last saw him alive on May 22 - 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis (Chronic)  
NEPHRITIS

Duration  
6 mo

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? \_\_\_\_\_  
(Specify type of place)

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

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 1316 N. Grand Date signed 5-23-40

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

**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 \_\_\_\_\_

Licensed Embalmer No. 1994

P. O. Address 6633 Clayton 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, above space should be left blank.**