

REC'D OCT 25 791

1003

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 7984

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Homer G. Phillips
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 days
(Specify whether years, months or days)

8. (a) PRINT FULL NAME William Howell

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

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

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

7. Birth date of deceased 8-31-1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 4 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 Unknown

13. Birthplace Unknown Ark.
(City, town, or county) (State or foreign country)

14. Maiden name Opal Howell
 15. Birthplace Malvern Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant father map Howard

(b) Address 2601 N. Whittier St.

17. (a) burial (b) Date thereof 9-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director W. Hamilton

(b) Address City Health Dept

19. (a) SEP 25 1940 (b) J. P. Brubaker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 21
(If outside city or town limits write "RURAL")
 (d) Street No. 1522a N. Garrison
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 3
 year 1940 hour 2 minute 40 A. M.

21. I hereby certify that I attended the deceased from 8-31-
1940, to 9-3-, 1940;

that I last saw him alive on 9-3-, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis (Newborn)
 Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy As above

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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature W. P. Race (M. D. or other) 8-23-40

Address 2601 N. Whittier Date signed _____

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.....

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, above space should be left blank.