

Registration District No. 784

Primary Registration District No. 111

Registrar's No. 335

I. PLACE OF DEATH:

(a) County St. Louis
(b) City or town RICHMOND HEIGHTS, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. MARYS HOSPITAL 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution HOSP. 2 days
(Specify whether
In this community 5 yrs.
years, months or days)

3. (a) PRINT FULL NAME WILLIAM HOWIS

3. (b) If veteran, name war NIL 3. (c) Social Security No. 496-14-6037

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife GISELDA HOWIS 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased JUNE 26 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 7 16 hr. min.

9. Birthplace ST. LOUIS MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation PAINTER

11. Industry or business PAINTING

MOTHER FATHER
12. Name JOSH HOWIS
13. Birthplace UNKNOWN UNKNOWN 9
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN UNKNOWN 9
15. Birthplace UNKNOWN UNKNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant Giselda Howis

(b) Address 9517 Lackland Rd. Overland Mo.

17. (a) ENTOMBMENT (b) Date thereof FEB. 15, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BELLEFONTAINE CEM

18. (a) Signature of funeral director Bluedmeyer & Co

(b) Address 2924 N. 22nd St.

19. (a) FEB 13 1941 (b) W. M. Murphy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS
(c) City or town OVERLAND
(If outside city or town limits, write "RURAL")
(d) Street No. 9517 Lackland Road
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 12
year 1941 hour 1130 minute P. M.

21. I hereby certify that I attended the deceased from Feb 10-12, 1941, to Feb 12, 1941 that I last saw him alive on Feb 12, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hem. Rt. Side
Duration 2 days

Due to Neoplasm ?
Due to _____

Other conditions no other
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: ✓
Of operations _____
Of autopsy ✓
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 Res. Bluedmeyer or other) D
Address 8705 Page Blvd signed 2-13-41

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

96
8
3

132

17-11
XXXX I
27

STATE OF ILLINOIS
DEPARTMENT OF HEALTH

STATE OF ILLINOIS
DEPARTMENT OF HEALTH

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 Prairie

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 4326

Registration District No.

Primary Registration District No.

Registrar's No. 325

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Rich. Hts.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME William Louis

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day..... h..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 2-12-41 (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month Feb. day 12-41
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death.....
Due to Nephritis
Due to chronic

Other conditions..... (Include pregnancy within 3 months of death)

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?

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

23. Signature Res. J. Qually (M. D. or other)
Address 165 Page Blvd Date signed 4-5-41

SUPPLEMENTARY

MEDICAL CERTIFICATION

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

