

No. 2
-4-41
1-30

FILLED NOV 3 1941
Registration District No. 784

Primary Registration District No. 200

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Normandy Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7500 St. Charles Rk. Rd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 26 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Virginia (b) County Pulaski
(c) City or town Pulaski
(If outside city or town limits, write "RURAL")
(d) Street No. Route 3
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Samuel Franklin Harrell

3. (b) If veteran, name war _____ 3. (c) Social Security No. 226-12-1308

20. DATE OF DEATH: Month Oct. day 27th
year 1941 hour 5 minute A M.

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

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Lettie 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

Immediate cause of death Natural causes. Duration _____

8. AGE: Years About 51 Months _____ Days _____ If less than one day _____ hr. _____ min.

Due to Lobar pneumonia of right lung.

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

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

10. Usual occupation Electrician

11. Industry or business Eruco Construction Co.

Major findings: Of operations _____
Of autopsy Yes.
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

12. Name James Harrell

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

14. Maiden name Unknown

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

16. (a) Informant Albert H. Pike

(b) Address 7500 St Charles Rd

17. (a) Removal (b) Date thereof 10 28 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pulaski Va

18. (a) Signature of funeral director James H. [unclear]
(b) Address 1111 [unclear]

19. (a) OCT 28 1941 (b) [unclear]
(Date received local [unclear]) (Registrar's signature)

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 James H. [unclear]
Address Kirkwood, Mo. Date signed 10/28/41

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

MOTHER FATHER

11/16/41

707

2011-11-17
4
1

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.....

Louis H Bopp
.....
working under my personal supervision.

Registered Apprentice No.

Signed.....
Louis H Bopp

Licensed Embalmer No. *921*

P. O. Address *Kukwood*

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.

EMBA 10, 1911 A

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36209
Registrar's No. 2186

Registration District No. 784

Primary Registration District No. 205

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:
(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 Samuel Franklin Howell

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 _____ years
7. Birth date of deceased 5-5-92
(Month) (Day) (Year)

8. AGE: Years about 51 Months 5 Days 2 If less than one day _____ 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 _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____
19. (a) 10-28-41 (b) E. G. [Signature]
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 Day 28 year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____
Due to _____
Other conditions _____
(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)
(c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

THE UNIVERSITY OF CHICAGO

Department of Chemistry

Office of the Director

Chicago, Illinois

January 15, 1949

Dear Sirs:

I am pleased to inform you that your application for admission to the Ph.D. program in Chemistry for the fall semester of 1949 has been accepted.

Your record in the undergraduate program is excellent, and we are confident that you will find the graduate work at the University of Chicago both challenging and rewarding.

You will be admitted to the Ph.D. program in Chemistry for the fall semester of 1949. Your advisor will be Professor [Name].

Please contact the Office of the Director at the University of Chicago for further information regarding admission procedures and financial aid.

Very truly yours,

Director

Office of the Director

University of Chicago