

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8416

State File No. \_\_\_\_\_  
Registrar's No. 2627

FILED MAR 20 1943  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Homer Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days  
(Specify whether years, months or days)

In this community 21 years

3. (a) PRINT FULL NAME William Hughes

3. (b) If veteran, name war None (c) Social Security No. 492-160961

4. Sex M 5. Color or Race Col. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Florence Hughes 6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased 7 - 6 - 1901  
(Month) (Day) (Year)

8. AGE: Years 41 Months 8 Days 2 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Janitor

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

MOTHER FATHER { 12. Name Unknown

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

{ 14. Maiden name Unknown

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

16. (a) Informant William Hughes

(b) Address 4015a Finney

17. (a) BURIAL (b) Date thereof Mar 20 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director Manuel Vnd. Co

(b) Address 4059 Finney Ave

19. (a) MAR 19 1943 J. J. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County JAT 12

(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")

(d) Street No. 4015a Finney Avenue  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 14,  
year 1943 hour 3 minute 45 P. M.

21. I hereby certify that I attended the deceased from March 1,  
19 43 to March 14, 19 43  
that I last saw him alive on March 14, 19 43  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage (History)  
Bronchopneumonia (Autopsy)

Duration 15 days  
Terminal

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions 13  
(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? \_\_\_\_\_

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

23. Signature S. E. Smith (M. D. or other) \_\_\_\_\_  
Address 260 Webster Date signed 3/17/43

**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.....

*William C. McDowell*, Registered Apprentice No.....  
working under my personal supervision.

Signed *William C. McDowell*

Licensed Embalmer No. *2114*

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, fact should be so stated above.**