

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26751**
Registrar's No. **7834**

SEP 11 1943

Registration District No. **318**

Primary Registration District No. _____

Registrar's No. **7834**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. John's Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5648a Maple Ave.**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Nellie Howard**

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

4. Sex **f** S. Color or race **W** 6. (a) Single, widowed, married, divorced, **single**

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

7. Birth date of deceased **July 3rd 1862**
(Month) (Day) (Year)

8. AGE: Years **81** Months **1** Days **27** If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **housework**

11. Industry or business _____

12. Name **Stephen Howard**

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

14. Maiden name **Mary Kelly**

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

16. (a) Informant **James J. Howard**

(b) Address **5648a Maple Ave.,**

17. (a) **burial** (b) Date thereof **9-2-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Sullivan Brothers**

(b) Address **2849 North Euclid Ave.,**

19. (a) **SEP 1 1943** (b) **J. J. Breda**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **30** year **1943** hour **1** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **8-28** to **8-30**, 19**43**
that I last saw him alive on **8-30-43**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Obstruction of Intestines**
Due to **due to strangulated**
hernia
Due to _____

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 **R. J. Paul** (M. D. or other) **0**
Address **392 Park** Date signed **8/31-43**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Dr. Bob Hyland,

3869 Park

Dr 1414

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 Albert J. Mayfield

Licensed Embalmer No. 3077

P. O. Address 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, fact should be so stated above.