

S. No. 2
FORM-2-43
5-17-39
I X35697

30942

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **8004**

FILED SEP 17 1943 8
Registration District No. _____

Primary Registration District No. **1003**

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 G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 days
(Specify whether _____)

In this community 28 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

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

(d) Street No. 3120 Brantner
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Howard

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

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased Not Known
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 2, year 1943 hour 5 minute 45 A. M.

21. I hereby certify that I attended the deceased from August 17, 1943 to September 2, 1943, that I last saw h. im. alive on September 2, 1943; and that death occurred on the date and hour stated above.

8. AGE: Years About 48 Months _____ Days _____ If less than one day _____ hr. _____ min.

Immediate cause of death Pulmonary Tuberculosis Duration Unk.

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Laborer

11. Industry or business Joseph Howard

12. Name Athens Ga.

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

14. Maiden name Elizabeth Eberhardt

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

MOTHER FATHER

16. (a) Informant Baroness Howard (b) Address 3120 Brantner Pl.

17. (a) Sept 8, 1943 (b) Date thereof Sept 8, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Washington Park Cem.

18. (a) Signature of funeral director A. L. Beal Und Co.
(b) Address 2726 Lucas Ave.

19. (a) SEP 8 1943 (b) _____
(Date received local registrar) (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? _____

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

23. Signature Alva Mason (M, D, or other) _____
Address 2601 Whittier Date signed 9/7/43

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4219th E. Jayuel

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.