S. No. 2
M—5-43
. 5-17-39
I X3667F

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 20 1943

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36494

Registration District No. 1818 Primary Registration District No. 1003 Registrar's No. 9863

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

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
Saint Anthony'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) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town Saint Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 2926 Saint Vincent Ave., 100 17 9
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Infant Howell

3. (b) If veteran, name war Nil

3. (c) Social Security No. Nil

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife Nil

6. (c) Age of husband or wife if alive Nil years

7. Birth date of deceased November (Month) 6 (Day) 1943 (Year)

8. AGE: Years | Months | Days | If less than one day 5 hr. min.

9. Birthplace Saint Louis (City, town, or county) 0 Missouri (State or foreign country)

10. Usual occupation Infant

11. Industry or business Nil

FATHER
12. Name Orson P. Howell
13. Birthplace Mill Spring (City, town, or county) 0 Missouri (State or foreign country)

MOTHER
14. Maiden name Thelma Smith
15. Birthplace Mill Spring (City, town, or county) 0 Missouri (State or foreign country)

16. (a) Informant Mr. O. P. Howell
(b) Address 2926 Saint Vincent Ave.,

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-8-43 (Month) (Day) (Year)
(c) Place: burial or cremation Mill Spring, Missouri

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) 11-10-43 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 6
year 1943 hour 11 minute 00 P M.

21. I hereby certify that I attended the deceased from Nov 6, 1943 to Nov 6, 1943
that I last saw her alive on Nov 6, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Male Formation of Brain +	
Due to Other Deformity	
Due to Cause Unknown	
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.

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 H S Moore (M. D. or other)
Address 921-S 18th Date signed

(Licensed Embalmer's Statement on Reverse Side)

(Moore) - 921 S 18th

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 G W Wilkinson

Licensed Embalmer No. 3575

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.