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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

420

State File No. _____

FILED FEB 4 1944 318

Registration District No. _____ Primary Registration District No. 1003

Registrar's No. 982

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: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
In this community Unknown (Specify whether years, months or days)

3. (a) PRINT FULL NAME Howard Herbert

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

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

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

7. Birth date of deceased: March 12 Unknown
(Month) (Day) (Year)

8. AGE: abt 75 Years Months Days If less than one day Unknown hr. min.

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

10. Usual occupation Unknown

11. Industry or business _____

12. Name Unknown 9

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 S T Coleman

(b) Address Homer G Phillips Hospital

17. Antoine Bon... (Date thereof) 1-27-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph

18. (a) Signature of funeral director W. J. Richter

(b) Address 3500 Ritz...

19. (a) JAN 31 1944 (Date received local registrar) J. J. ... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St Louis 17 2
(If outside city or town limits, write "RURAL") 92
(d) Street No. 1509a Walnut
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 25
year 1944 hour 5 minute 40 A. M.

21. I hereby certify that I attended the deceased from January 10, 1944, to January 25, 1944
that I last saw him alive on January 25, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease Duration Unknown

Due to _____

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 S. E. Smith (M. D. or other) _____
Address 2601 N Whittier St Date signed 1-27-44

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No.....

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.