

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1005

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

**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. Louis City Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution..... 6 days  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Arthur Britton

3. (b) If veteran, name war..... None 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race..... White 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..... April 8 1917  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>26</u>	<u>10</u>	<u>3</u>	hr. min.

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

10. Usual occupation Papercleaner

11. Industry or business.....

**MOTHER, FATHER**

12. Name Will Britton

13. Birthplace St. James Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Sadie Cox

15. Birthplace St. James Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Minnie Clark  
 (b) Address 7741 Weaver

17. (a) Burial (b) Date thereof 2-14-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... St. James, Mo.

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

19. (a) FEB 15 1944 (b) J. F. Brueck  
(Date received for registration) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Phelps  
(If outside city or town limits, write "RURAL")

(c) City or town..... St. James  
(If rural, give location)

(d) Street No.....

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 11th year 1944 hour 7:45 minute P.M.

21. I hereby certify that I attended the deceased from Feb. 5th 1944, to Feb. 11th 1944, that I last saw him alive on Feb. 11th 1944, and that death occurred on the date and hour stated above.

Immediate cause of death..... Tuberculosis - Pulmonary

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.

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..... Arthur Moore (M. D. or other).....  
 Address..... 1515 Lafayette Date signed 2/14/44

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

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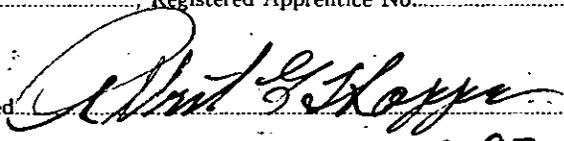
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**STATEMENT BY LICENSED EMBALMER**

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. 2971.....

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.**