

No. 2  
1-5-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 25 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16821

State File No. 4524  
Registrar's No. 000  
17 21

Registration District No. 318 Primary Registration District No. 1003

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:  
2021 1/2 Biddle.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2021 1/2 Biddle St  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Will Towne  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 10 day May year 1944 hour 11 minute 30 M.  
21. I hereby certify that I attended the deceased from May 2 to May 10 1944  
that I last saw him alive on May 10 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color Col 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mary Towne 6. (c) Age of husband or wife if alive 47 years  
7. Birth date of deceased Nov 1 1896  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage  
Due to Hypertension  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 47 Months 6 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Miss 1  
(City, town, or county) (State or foreign country)  
10. Usual occupation Labor

11. Industry or business \_\_\_\_\_  
12. Name John Towne  
13. Birthplace Miss 1  
(City, town, or county) (State or foreign country)  
14. Maiden name Bella  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Towne  
(b) Address 2021 1/2 Biddle St  
17. (a) Burial (b) Date thereof May 16, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park  
18. (a) Signature of funeral director J. G. Green  
(b) Address 2915 Franklin Ave  
19. (a) MAY 16 1944 (b) J. S. Budeck  
(Date received by 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. Signer J. O. Wherman (M. D. or other)  
Address 3047 1/2 Easton Date signed 5/10/44

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

MOYER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

844

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 *J. A. Green*.....

Licensed Embalmer No. *2963*.....

P.O. Address *2915 Franklin*.....

**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.**