

FILED OCT 24 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 353640
Registrar's No. 2103

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town KOCH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ROBERT KOCH HOSP. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 67 days
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

WILLIE STEPHEN

3. (b) If veteran,

name war NO

3. (c) Social Security

No. _____

4. Sex M MIDDLE

5. Color or race NEGRO

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

6. (b) Name of husband or wife HELEN JONES

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

7. Birth date of deceased 1 - 8 - '04
(Month) (Day) (Year)

8. AGE:

Years 40

Months 9

Days 6

If less than one day

hr. _____ min.

9. Birthplace

CASS CO. TEXAS
(City, town, or county)

(State or foreign country)

10. Usual occupation

DISK WASHER

11. Industry or business

MOTHER FATHER

12. Name GREEN, STEPHEN

13. Birthplace CASS CO TEXAS
(City, town, or county) (State or foreign country)

14. Maiden name ELLA HAWKINS

15. Birthplace CASS CO TEXAS
(City, town, or county) (State or foreign country)

16. (a) Informant

PATIENT

(b) Address

17. (a) BURIAL
(Burial, cremation, or removal)

(b) Date thereof OCT. 16 44
(Month) (Day) (Year)

(c) Place: burial or cremation CASS COUNTY TEXAS

18. (e) Signature of funeral director ROYD BRUS FUNERAL HOME

(b) Address 3704 FINNEY AVE.

19. (a) OCT 16 1944 (Date received local registrar)
(b) G. J. McLawman M.D. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 3426 HICKORY
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 14
year 1944 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from 8 - 8, 1944, to 10 - 14, 1944.
that I last saw him alive on 10 - 14, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death

Multiple Lung Abscess

Duration

6 mo. (?)

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Multiple Lung Abscess

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 0

23. Signature Thomas J. Rice (M. D. or other)
Address Koch Hosp. Koch, Mo. Date signed 10/15/44

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

600

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.....

William C. McDowell....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *William C. McDowell*.....

Licensed Embalmer No..... *2117*.....

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.