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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED FEB 24 1945
 Registration District No. **318**

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
 Primary Registration District No. **1003**

4365
 State File No. _____
 Registrar's No. **1312**

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

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 17 days
(Specify whether years, months or days)
 In this community 15 years

3. (a) PRINT FULL NAME Armstead Holle
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 2 5. Color or race Col.
 6. (a) Single, widowed, married, divorced Widow 2
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased about Dec 1st 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>2</u>	<u>5</u>	hr. _____ min. _____

9. Birthplace Grange (City, town, or county) - Ga 1 (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

12. Name John Holle

13. Birthplace York Va 1 (City, town or county) (State or foreign country)

14. Maiden name Holliday

15. Birthplace Grange Ga 1 (City, town, or county) (State or foreign country)

16. (a) Informant John See See
 (b) Address 1356 Glasgow Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 10-1945
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J. H. Randle & Son
 (b) Address 3133 Bell Ave

19. (a) **FEB 9 1945** (b) J. H. Randle
(Date received local registrar) (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. 1356 Glasgow
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 6, year 1945 hour 12 minute 35 P. M.

21. I hereby certify that I attended the deceased from January 20, 1945, to February 6, 1945;

that I last saw him alive on February 6, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia (Terminal)
 Duration _____

Due to Arteriosclerotic Gangrene of right foot Indef.

Due to _____

Other conditions 107
(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 W. C. Casloway (M. D. or other) _____
 Address 2601 Whitefig Date signed 2/8/45

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.