

S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 4739  
Registrar's No. 1003

Registration District No. 318

Primary-Registration District No. 1003

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

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:  
3627 Palm Str.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3627 Palm Str.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME William Thomas Hart,

3. (b) If veteran, name war.....

3. (c) Social Security No. 494-05-3281

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Jennie Hart

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased May 28, 1885  
(Month) (Day) (Year)

8. AGE: Years 59 Months 11 28 days  
If less than one day hr. min.

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

10. Usual occupation Life Insurance Salesman

11. Industry or business.....

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Jennie Hart

(b) Address 3627 Palm Str.

17. (a) Burial (b) Date thereof 5/29/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director [Signature]  
2117 E. Grand Blvd.

(b) Address

19. (a) MAY 29 1945 J. P. Brodeur  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26  
year 1945 hour 6 minute 05 A.M.

21. I hereby certify that I attended the deceased from January 3 1945, to May 25 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 6 mos. at least

Due to Hypertension

Due to Nephritis, Chronic

Other conditions (Include pregnancy within 3 months of death) [Signature]

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?

23. Signature Dr. E. R. Westaver (M. D. or other) 00  
Address 3700 N. Grand Date signed 5-26-45

While at work? (Specify type of place)..... (c) Means of injury.....

**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 Frank A. Moore  
Licensed Embalmer No. 3041  
P. O. Address 2117 E. Grand

**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.**