

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

18586

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **5702**

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:
5366 Cabanne Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
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") **17**
(d) Street No. **5366 Cabanne Ave.**
(If rural, give location) **75**
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Horatio C. Broadwell**
3. (b) If veteran, name war _____
3. (c) Social Security No. **492-20-0965**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **29th.**
year **1945** hour **6.35** minute **A.** M.

4. Sex **Male** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Irene Broadwell**
6. (c) Age of husband or wife if alive **67** years
7. Birth date of deceased **Jan. 20th, 1871**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **26, 1945** 19. to **June 29, 1945**
that I last saw him alive on **June 28, 1945**
and that death occurred on the date and hour stated above.

8. AGE: Years **74** Months **5** Days **9**
If less than one day hr. _____ min. _____

Immediate cause of death **Cardiac failure**
Cardiac asthma Duration **1-26-45**

9. Birthplace **KY**
(City, town, or county) (State or foreign country)
10. Usual occupation **Engineer-Mines Equipment**

Due to **Myocardial failure** **1-26-45**
Chronic myocarditis
Due to **Age & vessels - 67 years**
Cardiac renal hypertrophy **years**

11. Industry or business _____
12. Name **George Broadwell**
13. Birthplace **Dont Know** **9**
(City, town, or county) (State or foreign country)
14. Maiden name **Irene Clark**
15. Birthplace **Dont Know** **7**
(City, town, or county) (State or foreign country)

Other conditions _____
(Include pregnancy within 3 months of death)

16. (a) Informant **Irene Broadwell**
(b) Address **5366 Cabanne Ave.**
17. (a) **Burial** (b) Date thereof **7-2-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Grove Cemetery**

Major findings: _____
Of operations **1/31**
Of autopsy _____
PHYSICIAN _____

18. (a) Signature of funeral director **Provost Und. Co.**
(b) Address **3710 N. Grand Bl.**
JUN 30 1945 (Date received local registrar) (b) **J. F. Bredbeck** (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? _____

19. (a) _____ (b) _____ (c) _____
23. Signature **Franklin Clark** (M. D. or other) **6-25-45**
Address **St. Louis, Mo** Date signed **6-25-45**
St. Louis, Mo

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

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J. F. W. Clarke
864 Hamilton
1800 - 8 P.M.
CR 2354

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis, Mo.

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.