

No. 2  
1-5-43  
5-17-39  
I X36671

FILED 09185 1945

Registration District No. .... Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(c) Name of hospital or institution: 3421<sup>a</sup> LaSalle  
(d) Length of stay: In hospital or institution 9 yrs  
In this community 9 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County cc  
(c) City or town St Louis  
(d) Street No. 3421<sup>a</sup> LaSalle  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME MINNIE HOWARD

3. (b) If veteran, name war. .... 3. (c) Social Security No. ....

4. Sex FEMALE 5. Color or race col  
6. (a) Single, widowed, married, divorced WIDOW  
6. (b) Name of husband or wife WIDOW  
6. (c) Age of husband or wife if alive 18.4.71 years

7. Birth date of deceased June (Month) 18 (Day) 1847 (Year)

8. AGE: Years about 98 Months - Days - If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

12. Name DANIEL LOCKHART

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

14. Maiden name Wendy Lockhart

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

16. (a) Informant MINNIE DAY'S

(b) Address 3421<sup>a</sup> LaSalle

17. (a) Removal (b) Date thereof Oct 7-45  
(c) Place: burial or cremation Springfield Ala

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 4 year 1945 hour 2 minute 30P M.

21. I hereby certify that I attended the deceased from Oct 4 1945 to Oct 4 1945 that I last saw him alive on Oct 4 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Sclerosis  
Due to Generalized Atherosclerosis

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: None  
Of operations None  
Of autopsy None

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) None  
(b) Date of occurrence None  
(c) Where did injury occur? (City or town) (County) (State) None  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? None

23. Signature Estimate E. Taylor (M. D. or other) None  
Address None Date signed 10/4/45

**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.....

*J. Watson*

Licensed Embalmer No. *2698*

P. O. Address *2769 Chouteau*

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. NovRegistration District No. 318Primary Registration District No. 1003Registrar's No. 8631

## 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:  
 (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)

3. (a) PRINT  
FULL NAMEMinnie Howard3. (b) If veteran,  
name war.....3. (c) Social Security  
No.....4. Sex F 5. Color or  
race B 6. (a) Single, widowed, married,  
divorced wid6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if  
alive.....7. Birth date of deceased June  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
ast 98 hr. min.9. Birthplace.....alg  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER } 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) OCT 30 1945 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

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

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 30  
year 1945 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....

that I last saw him..... alive on....., 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)Major findings:  
Of operations.....

Of autopsy.....

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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..... (M. D. or other).....

Address..... Date signed.....

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

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