. S. No. 2
0M—2-43
ev. 5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 32483

FILED NOV 2 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9322

1. PLACE OF DEATH
(a) County St Louis
(b) City or town St Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Nos Ho=10
(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 Mo (b) County 000
(c) City or town St Louis 17
(If outside city or town limits, write "RURAL").
(d) Street No. 603 N. 6th St 259
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) 0
If yes, name country .....

3. (a) PRINT FULL NAME Horatio Waters.
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex Male
5. Color or race White
6. (a) Single, ~~widowed, married, divorced~~ 0
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased ..... (Month) (Day) (Year)
8. AGE: Years 84 Months Days If less than one day ..... hr. ..... min.
9. Birthplace (City, town, or county) Illinois (State or foreign country)
10. Usual occupation Laborer
11. Industry or business Unknown
MOTHER FATHER
12. Name Unknown
13. Birthplace (City, town, or county) Unknown (State or foreign country)
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Mr. Gallaway
(b) Address Bon Clair Ave
17. (a) Anatomical Board (Burial, cremation, or removal) Date thereof 10-24-45 (Month) (Day) (Year)
(c) Place: burial or cremation St Louis
18. (a) Signature of funeral director W. Rutger
(b) Address 3700 Rutger St
19. (a) OCT 29 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11 year ..... hour 10 minute 12 noon
21. I hereby certify that I attended the deceased from ....., 19....., to ....., 19.....;
that I last saw him ..... alive on ....., 19.....;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Cirrhosis of Liver | |
| Due to P.M.A. | |
| 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 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? .....
(Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature ..... (M. D. or other)
Address ..... Date signed 10/22/45

(Licensed Embalmer's Statement on Reverse Side)

## 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.**