V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35416

FILED DEC 12 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10589

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

1. PLACE OF DEATH:

(a) County

(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: St. Louis City Hospital ()
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1mo-4 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis 2 25
(If outside city or town limits, write "RURAL")

(d) Street No. 1609 Market St.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME JOHN WESLEY HOWARD

3. (b) If veteran, name war No.

3. (c) Social Security No. 429-36-7118

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widower 2

6. (b) Name of husband or wife Unk.

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

7. Birth date of deceased About (Month) (Day) 1881 (Year)

8. AGE: Years About 64 | Months | Days | If less than one day hr. min.

9. Birthplace Smithville (City, town, or county) Ark. 1 (State or foreign country)

10. Usual occupation Machine Operator

11. Industry or business

FATHER
12. Name Wm. Morris Howard
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Sarah Taylor
15. Birthplace Smithville (City, town, or county) Ark. 1 (State or foreign country)

16. (a) Informant Jesse Howard
(b) Address Smithville, Ark.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-6-45 (Month) (Day) (Year)
(c) Place: burial or cremation Smithville, Ark.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) DEC 5 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 4th year 1945 hour 5;15 minute P M.

21. I hereby certify that I attended the deceased from 10/30/45, 19, to 12/4/45, 19; that I last saw him alive on 12/4/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Ulcerative cystitis & (pyelitis-non-calculous

Due to

Due to 133

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 O. Lee Hewitt 1515 Lafayette 12/5/45 (M.D. or other) MD

Address Date signed

(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. 3525

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.