

FILED JAN 11 1945
318

State File No. _____

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. 11502

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
in this community 21 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. 218 S. 4th St.,
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CHARLES HOWARD

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, widower 2 divorced widower

6. (b) Name of husband or wife Unk. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 2nd, ??
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
abt - 74 hr. min.

9. Birthplace VA-VIRGINIA (City, town, or county) (State or foreign country)
Unk.

10. Usual occupation _____

11. Industry or business _____

12. Name George Howard

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

14. Maiden name Henrietta Unk.

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Anatomical (Burial, cremation, or removal) Date thereof 12-5-45
(Month) (Day) (Year)
(c) Place: burial or cremation Washington

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

(b) Address 2805 Rutledge St

19. (a) DEC 28 1945 (Date received local registrar) J. F. Brueck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30th
year 1945 hour 8:50 minute P M.

21. I hereby certify that I attended the deceased from 11/26/45
19____ to 11/30/45 19____
that I last saw h. in alive on 11/30/45 19____
and that death occurred on the date and hour stated above.

Immediate cause of death
1. Arteriosclerotic Heart Disease
and nephritis, Chro.
2. Prostate Hypertrophy

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 12/1

Major findings:
Of operations _____
Of autopsy _____

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 W. Dalton (M.D. or other) M.D.
Address 1515 Lafayette Date signed 12/1/45

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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.