

S. No. 2  
M-5-42  
v. 5-17-39  
I X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED** APR 17 1946

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14660

State File No. ....

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3091**

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 19 days  
(Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
Missouri  
(a) State..... (b) County.....  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6104 Washington  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Helen A. Douglas  
3. (b) If veteran, name war No. 3. (c) Social Security No. ....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 1  
year 1946 hour 5: minute 30 P.M.  
21. I hereby certify that I attended the deceased from 1-23-46  
....., 19....., to 4-1-46....., 19.....;

4. Sex F. / 5. Color or race W.  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if  
alive..... years  
7. Birth date of deceased July 1872  
(Month) (Day) (Year)

that I last saw h. er alive on 4-1-46....., 19.....;  
and that death occurred on the date and hour stated above.  
Immediate cause of death chronic myocarditis Duration  
with myocardial failure

8. AGE: Years Months Days If less than one day  
73 8 3 hr. min.

Due to hypertension, very high  
Due to arterio sclerotic kidney

9. Birthplace St. Louis, Mo. /  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)  
no

10. Usual occupation Housewife

Major findings:  
Of operations no

11. Industry or business

Of autopsy no

12. Name James McQ. Douglas

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

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

14. Maiden name.....

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

16. (a) Informant Miss Florence M. Douglas  
(b) Address 6104 Washington

17. (a) burial (b) Date thereof 4-3/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director Alexander Sons  
(b) Address 6175 Delmar

19. (a) APR 2 1946 (b) J. F. Medelch  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(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? no (Specify type of place) (e) Means of injury C

23. Signature C. H. Harrison (M. D. or other)  
Address 306 Humboldt Bldg. Date signed 4/2/46

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

MOTHER FATHER

135

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**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 *jos. E. McCallister*  
Licensed Embalmer No. *2960*  
P. O. Address *6170 Pellman*

**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.**