. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 12 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

24902

State File No. 0

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1625

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town KOCH, MO (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ROBERT KOCH HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 74 DAYS (Specify whether

In this community 74 DAYS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ~~St. Louis~~

(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL")

(d) Street No. 2910 MADISON (If rural, give location)

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

If yes, name country ✓

3. (a) PRINT FULL NAME ROY WENSTON HOUSE

3. (b) If veteran, name war ?

3. (c) Social Security No. YES

4. Sex MALE

5. Color or race NEGRO

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CHRISTINE HOUSE

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

7. Birth date of deceased 9 (Month) 9 (Day) 15 (Year)

8. AGE: Years 30 Months 10 Days 22 If less than one day ✓ hr. ✓ min.

9. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country)

10. Usual occupation PAINTER

11. Industry or business ✓

FATHER
12. Name SCOTT HOUSE
13. Birthplace ✓ (City, town, or county) TENNESSEE (State or foreign country)

MOTHER
14. Maiden name ETHEL MOORE
15. Birthplace ✓ (City, town, or county) TENNESSEE (State or foreign country)

16. (a) Informant HOSPITAL RECORDS

(b) Address KOCH HOSPITAL, KOCH, MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 (Month) 5 (Day) 46 (Year)

(c) Place: burial or cremation Father Dickson

18. (a) Signature of funeral director A D Richardson

(b) Address 2625 Glasgow

19. (a) 8-5-46 (Date received local registrar) (b) E G McGenan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 31st year 46 hour 3 minute 50 A.M.

21. I hereby certify that I attended the deceased from 5-17-46, 19__, to 7-31, 1946 that I last saw him alive on 7-31, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death BRONCHOGENIC CARCINOMA	ABOUT 5 MONS ?
Due to 476	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy BRONCHOGENIC CARCINOMA

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 [signature] (M. D. or other)

Address ROBERT KOCH HOSP. KOCH, MO. signed 7-31-46

(Licensed Embalmer's Statement on Reverse Side)

AUG 27 1946

AUG 27 1946

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 A. D. Richardson

Licensed Embalmer No. 2928

P. O. Address City

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.