S. No. 2
OM—2-43
v. 5-17-39
I X38697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 30 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24903

Registration District No. 317 — Primary Registration District No. 6876 — Registrar's No. 1365

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: 131 days (Specify whether years, months or days)
In this community: 14 years in St Louis

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: 09
(c) City or town: St. Louis. (If outside city or town limits, write "RURAL")
(d) Street No.: 4523 NEWBERRY TERRACE (If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: HOWARD VERNICE (FIRST NAME)
3. (b) If veteran, name war: no
3. (c) Social Security No. 486-12-2307
4. Sex: female
5. Color or race: colored
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: DAVID HOWARD.
6. (c) Age of husband or wife if alive: 29 years
7. Birth date of deceased: NOV - 15 1918 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
27. 27	8	6	hr. min.

9. Birthplace: HELENA ARKANSAS (City, town, or county) (State or foreign country)
10. Usual occupation: FILE CLERK
11. Industry or business:
MOTHER FATHER
12. Name: JIMMIE JAMES
13. Birthplace: ARKANSAS (City, town, or county) (State or foreign country)
14. Maiden name: CARRIE WALTERS
15. Birthplace: ARKANSAS (City, town, or county) (State or foreign country)
16. (a) Informant: KOCH HOSPITAL RECORD.
(b) Address: KOCH MO.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-26-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Washington Park
18. (a) Signature of funeral director: E. J. Nash
(b) Address: 7847 Page
19. (a) 7-26-46 (Date received local registrar) (b) [illegible] (Registrar's signature) M.D.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1946 hour 5 minute 25 A.M.
21. I hereby certify that I attended the deceased from March-12-1946, 19..., to July 21-, 1946; that I last saw him alive on July 21, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary tuberculosis	7 months
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: none performed	

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: [illegible] (M. D. or other) M.D.
Address: Koch Hospital Date signed 7-21-46

NOV 30 1948

SEP 6 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 C. J. Nash

Licensed Embalmer No. 3432

P. O. Address 3847 Pogue

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.