

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 9 1946
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

39235

State File No. _____
Registrar's No. 10185

Registration District No. _____ Primary Registration District No. _____

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:
Childrens. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 Days
(Specify whether years, months or days) 19 Days.

3. (a) PRINT FULL NAME James Ray Willhite
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Child
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 8, 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 19 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Charles Willhite
13. Birthplace Washington, Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Truma Toney
15. Birthplace Scott Co., Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Willhite.
(b) Address 5032 Minerva Ave.

17. (a) Burial (b) Date thereof 11 - 30 - 46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery.

18. (a) Signature of funeral director Donhart & Goodhart
(b) Address 2228 St. Louis Ave.

19. (a) NOV 29 1946 (b) J. F. Bradock
(Date received local) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 5032 Minerva, Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 27
year 46 hour 6 minute 00 A.M.
21. I hereby certify that I attended the deceased from 11-12 1946 to 11-27 1946;
that I last saw him alive on 11-27 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
Congenital heart disease
Aspiration pneumonia

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

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature K. J. B. H. (M. D. or other) _____
Address 5032 Minerva Ave. Date signed _____

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 *Mapie A. Cashion*
Licensed Embalmer No. *3949*
P. O. Address *St. Louis Mo*

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.