S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

35866

State File No. 9339

FILED OCT 24 1947

Registration District No. bist. 78165 318

Primary Registration District No. 1003

Registrar's No.

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

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: 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 (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County aoo

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 2021 Bissell (If rural, give location) 9

(e) Citizen of foreign country? (Yes or No) 9

If yes, name country

3. (a) PRINT FULL NAME Sarah E. Howell

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Lee Howell

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased February (Month) 10 (Day) 1870 (Year)

8. AGE: Years 77 Months 7 Days 27 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) (State or foreign country) 9

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name James Wyatt 9
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Abbygail Sullivan
15. Birthplace Mississippi (City, town, or county) (State or foreign country)

16. (a) Informant Earl Burcham

(b) Address St. Charles, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-47 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) OCT 8 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7th year 1947 hour 1:35 minute A M.

21. I hereby certify that I attended the deceased from 10-4-47, 19, to 10-7-47, 19; that I last saw her alive on 10-7-47, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, RLL

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 108

Major findings:
Of operations

Of autopsy as above

Duration days

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) none

(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? none (Specify type of place)

While at work? (e) Means of injury

23. Signature Robert L. Gilbert (M. D. or other) MD

Address 1515 Lafayette Date signed 10-7-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.....Elmo R. Cadwell.....

Licensed Embalmer No.....4077.....

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.