

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

35902

FILED NOV 4 1949

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 4190

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town) Wellston		c. CITY (If outside corporate limits, write RURAL and give township) Wellston, Missouri	
c. LENGTH OF STAY (in this place) 3 yrs		d. STREET ADDRESS (If rural, give location) 6144 Minerva Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6144 Minerva Avenue			
3. NAME OF DECEASED (Type or Print) a. (First) IOWA		b. (Middle) JAMES	
c. (Last) HOWELL		4. DATE OF DEATH (Month) (Day) (Year) 10/18/49	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH 7/23/1868	
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Murphy, North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unknown Abernathy		13b. MOTHER'S MAIDEN NAME Harriet Unknown	
14. NAME OF HUSBAND OR WIFE unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Alva Cloyd, 4181 Delmar Blvd.		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 420.0	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 1948 to Oct 18, 1949 , that I last saw the deceased alive on Oct 18, 1949 , and that death occurred at 10 a. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Edward B. Williams M.D.		23b. ADDRESS 4242 Easton Avenue	
23c. DATE SIGNED 10-19-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/22/1949	
24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REG. 10-20-49		REGISTRAR'S SIGNATURE Herbert W. Burke	
25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates, 4107 Finney Avenue		ADDRESS	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John R Cunningham
Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.