

FILED SEP 9 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27808

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6737**

1. PLACE OF DEATH a. COUNTY		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) St. Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Webster Groves 460
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		e. STREET ADDRESS (If rural, give location) 807 South Berry Street	

3. NAME OF DECEASED (Type or Print)	a. (First) Edna	b. (Middle) W.	c. (Last) Howze	4. DATE OF DEATH (Month) (Day) (Year) 8 2 55
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 10-19-1869	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Mississippi	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Robert Williams	13b. MOTHER'S MAIDEN NAME Mary Elizabeth White	14. NAME OF HUSBAND OR WIFE James A. Howze
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 494-28-3382A	17. INFORMANT'S SIGNATURE OR NAME Thomas B. Howze, Kirkwood, Mo. ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5-6 days
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho-pneumonia, bilateral		
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	20. AUTOPSY? 491X YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **Oct. 4, 1954**, to **Aug 2, 1955**, that I last saw the deceased alive on **Aug 2, 1955**, and that death occurred at **11:25 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE W. K. [Signature] (Degree or title)	23b. ADDRESS 5100 Arsenal Street St. Louis	23c. DATE SIGNED Aug 2, 55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE 8-4-55	24c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. AUG 3 1955	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Parker-Aldrich, Webster Groves, Mo. ADDRESS
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WRITE PLAINLY—USING 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 No Embalming, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....Leslie Stalch

Licensed Embalmer No. 439

P. O. Address Wester

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.