

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

REG. NO. 2266 313

SL 4396

= 62-020536

FILED MAY 23 1962

Primary Registration District No. 1003

Registrar's No. 4756

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1	2	3	4	5	6	7	8	9	10	11	12	13
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DATE AMENDED 6/8/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF 10/11/1891 & 70

10/11/1900 & 61

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF Informant DOCUMENT Press I.D. Papers

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. Grand, St. Louis, Mo.		Length of stay in 1b 1 hr. 25 min.	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4871 Fountain Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JOHN T. HOWARD			4. DATE OF DEATH Month Day Year May 8 1962
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/11/91900 70 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newsman		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 70 61 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11a. BIRTHPLACE (City and state or country) Jefferson City, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME HENRY HOWARD		13b. MOTHER'S MAIDEN NAME KATIE MILLER	
14. NAME OF HUSBAND OR WIFE -----		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> NW-1	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Fay R. Thomas (Niece), Same add. as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA WITH CONSOLIDATION			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 490x			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour p.m.	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) VA	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 5/7/62 to 5/8/62 and last saw DEK him live on 5/8/62		Death occurred at 12:35 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <i>Paul J. Simon</i> Deputy Coroner		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 5/9/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-14-62	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS G. Wade Granberry 4202 Finney Ave.		25. DATE RECD. BY LOCAL REG. MAY 9 1962	26. REGISTRAR'S SIGNATURE <i>Loed Smith, M.D.</i>

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 _____
Signature of Student Embalmer

Signed Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.

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.

STATE OF ILLINOIS
DEPARTMENT OF HEALTH
DIVISION OF ANATOMY
CHICAGO, ILL.