

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16163

State File No. _____

Registration District No. 284

Primary Registration District No. 200

Registrar's No. 677

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Admitted 4/2/40
(Specify whether years, months or days)

3. (a) PRINT FULL NAME 453 William Rowland

3. (b) If veteran, name war World War 3. (c) Social Security No. -

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased September 20, 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 6 16 hr. 1 min.

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

10. Usual occupation Wire Hanger 4

11. Industry or business Coal Mine 11

12. Name - Rowland, 1

13. Birthplace Wales, England
(City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Walls

15. Birthplace Wales, England
(City, town, or county) (State or foreign country)

16. (a) Informant M. Schuller

(b) Address Clinical Clerk, Vet. Adm. Bldg., Jeff. Bks., Mo.

17. (a) Removal (b) Date thereof 4-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ladd, Illinois

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) APR - 7 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
(c) City or town Gillespie
(If outside city or town limits, write "RURAL")
(d) Street No. P.O. Box 3.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? - years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6
year 1940 hour 3:20 minute a.m.

21. I hereby certify that I attended the deceased from April 2, 1940, to April 6, 1940
that I last saw him alive on April 6, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Heart disease due to pulmonary hypertension, myocardial damage and myocardial insufficiency. Duration unkn.

Due to 928

Other conditions Chronic bronchial asthma and chronic bronchitis. unkn.

Major findings: Of operations No operation PHYSICIAN _____
Of autopsy _____ Underline the cause to which death should be charged statistically.

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? _____

While at work Harry Levine (Specify type of place) (e) Means of injury _____

23. Signature HARRY LEVINE, M.D. (M. D. or other) _____
Address Acting Ch. Med. Off., VAF, Jeff. Bks., Mo. Date signed _____

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

MOTHER FATHER

[Faint, mostly illegible text from the reverse side of the certificate is visible through the paper.]

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 *J. G. Sullivan*

Licensed Embalmer No. *1122*

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16166
Registrar's No. 677

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 754

Primary Registration District No. 200

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

1. PLACE OF DEATH
(a) County St. Louis
(b) City or town Suffern Burns
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? years

3. (a) PRINT FULL NAME Willie Rowland
3. (b) If veteran, name war 3. (c) Social Security No.

20. DATE OF DEATH Month Apr day 6
year 1940 hour minute M.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced Div
6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death

8. AGE: Years Months Days If less than one day
48 6 18 min.

Due to
Due to
Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant (b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 4-7-40 (b) TR Meyer (Date received local registrar) (Registrar's signature)

PHYSICIAN
Underline the cause to which death should be charged statistically.

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature Harry Leune (M. D. or other)
Address Jeff Biers Date signed

SUPPLEMENTARY

RECEIVED
MAY 10 1964
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.