MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Clay

Township Gallatin

or

Village ~~Mt. Hanover~~

or

City _____ (NO. _____ St.: _____ Ward)

Registration District No. 197 File No. 27746

Primary Registration District No. 5276 Registered No. 27

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Eli Howell

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: July (Month) 13 (Day), 1907 (Year)

AGE: 4 yrs. ___ mos. 4 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): A

BIRTHPLACE (City or town, State or foreign country): Randolph Mo

PARENTS

NAME OF FATHER: Clarence Howel

BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo

MAIDEN NAME OF MOTHER: Nelly Johnson

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Howel

(ADDRESS) Harlem

Filed 8/30, 1911. T J Ward REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July (Month) 7 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from ___, 191__, to ___, 191__, that I last saw h___ alive on ___, 191__, and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

183 Drowning

Accident

164

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) H M Dagg M. D.

Aug 4, 1911 (Address) Harlem

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Germe Cemetery

DATE OF BURIAL: July 8, 1911

UNDERTAKER: None

ADDRESS: —

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death),

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Village..... Primary Registration District No..... Registered No.....

or

City .....(NO....., ... St.;.....Ward)

[If death o hospital or give its NA of street and

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....
(Month) (Day)

I HEREBY CERTIFY, that I attended deceas

....., 191...., to.....

that I last saw h.....alive on.....

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed).....

....., 191.... (Address).....

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LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSI RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIA
UNDERTAKER	ADDRESS