PLACE OF DEATH

County: Lewis

Township: ~~Canton~~ or Village: Canton or City: Canton Mo (NO. ____ St.: ____ Ward)

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

Registration District No. 479 File No. 33378

Primary Registration District No. 4286 Registered No. 94

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

FULL NAME Earl Leroy Howard

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	single

DATE OF BIRTH: aug (Month) 31 (Day), 1913 (Year)

AGE: ____ yrs. 1 mos. 19 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: infant
(b) General nature of industry, business, or establishment in which employed (or employer): none 0 - 0

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

PARENTS
NAME OF FATHER: John Howard
BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo.
MAIDEN NAME OF MOTHER: Edith Jones
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Howard

(ADDRESS) Canton Mo

Filed Oct 23, 1913 C. O. Shanks REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct. (Month) 20th (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 16th, 1913, to Oct. 20, 1913, that I last saw him alive on Oct 20, 1913, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cholera infantum
119A

(Duration) ____ yrs. ____ mos. 4 ds.

Contributory (SECONDARY) Dispepsia

(Duration) ____ yrs. ____ mos. 4 ds.

(Signed) D. W. A. Rebo M. D.

Oct. 20th, 1913 (Address) Canton

*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. 1 mos. 19 ds. In the State ____ yrs. 1 mos. 19 ds.

Where was disease contracted ~~if not at place of death~~? Canton Mo

Former or usual residence: Canton Mo

PLACE OF BURIAL OR REMOVAL: Canton Mo

DATE OF BURIAL: Oct 21, 1913

UNDERTAKER: H. R. Kreitz

ADDRESS: Canton Mo

PLACE OF DEATH

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

County.....

Township ..... Registration District No..... File No.....

or

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

or

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

[If death occurr hospital or ins give its NAME of street and nu

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

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

I HEREBY CERTIFY, that I attended deceased

....., 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).....

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT 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 BURIAL
	....., 1
UNDERTAKER	ADDRESS

genital," "Senile," etc.), "Dropsy," "Exhaustion," "Ma failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "Pu

industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second state-