

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

Do not use this space.

*Rhea*  
**24616**

**1. PLACE OF DEATH**

County Benton Oregon Registration District No. 632  
Township Wagner Primary Registration District No. 4382  
City (No. St. Ward)

File No. 24616  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Billie Frank Howell  
(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ervinia Chedus

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-20-1861

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>67</u>	<u>10</u>	<u>27</u>		

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) Self - Oregon Co. Inc  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oregon Co. Inc

10. NAME OF FATHER Casper Howell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) "

14. INFORMANT Wm Howell  
(Address) Wagner, Mo.

May 18 1928 Rhea  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-17-1928

17. I HEREBY CERTIFY That I attended deceased from May 30, 1928, to July 17, 1928 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at 100 p m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Chronic Interstitial Nephritis  
131 (duration) 1 yrs. 7 mos. 13 ds.

**CONTRIBUTORY (SECONDARY)**

18. WHERE WAS DISEASE CONTRIBUTED? 12900

IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? Albha M. D.

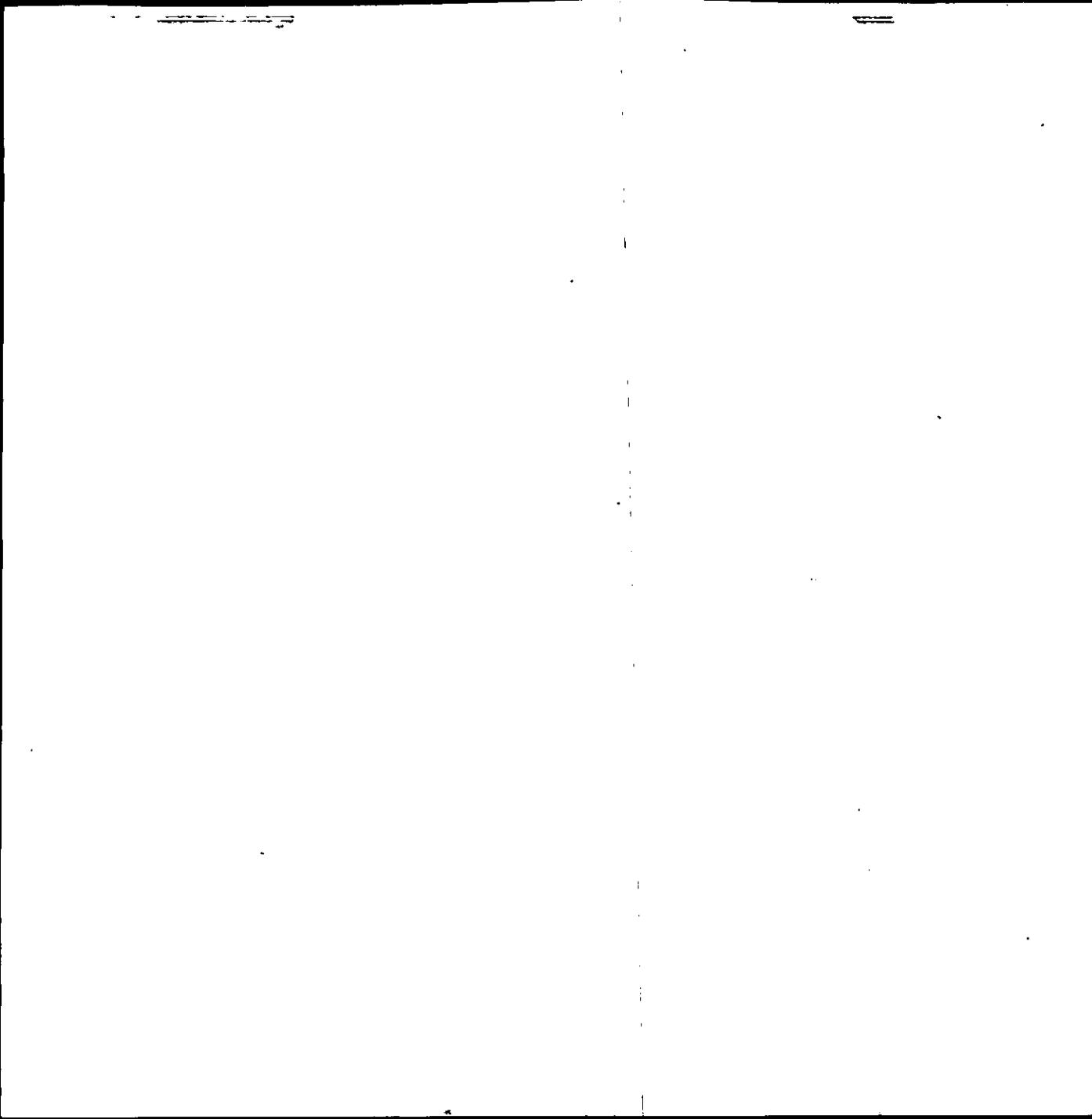
(Signed) Wagner Mo  
July 15, 1928 (Address)

\*State the DISEASE CAUSING DEATH, or in cases from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Howell Cemetery 7-18-28

20. UNDERTAKER ADDRESS A L Carr Meyer Inc



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Oregon Registration District No. 637 File No. ....  
 Township Mayer Primary Registration District No. 4387 Registered No. ....  
 City..... (No.....) St. .... Ward)

**2. FULL NAME**

Billie Frank Howell

(a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 20 - 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
66 10 27

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) .... yrs. .... mos. .... ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....  
 (c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY)

14. INFORMANT (Address)

15. July 18 28 to Shea REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 17 1928

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19.....  
 that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) ..... (duration) .... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
 WAS THERE AN AUTOPSY?.....  
 WHAT TEST CONFIRMED DIAGNOSIS.....  
 (Signed)....., M. D.  
 , 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

PARENTS

S-24616