

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

Do not use this space.

43179

1. PLACE OF DEATH

County..... Registration District No.....
 - Townshp..... Primary Registration District No.....
 City St. Louis, Mo. (No.) St. John Sloops.

File No.....
 Registered No. 12485
 St..... Ward.....

2. FULL NAME

Edores Howell
 (a) Residence. No. 4205 Junata St., 16 Ward.
 (Usual place of abode)
 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 15 - 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 3 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None
 (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) St. Louis, Mo.

10. NAME OF FATHER Edward F. Howell

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

12. MAIDEN NAME OF MOTHER Clara Boy

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

14. INFORMANT (Address) Edward F. Howell
4205 Junata St.

15. FILED 21 1928 W. C. Tanker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 19 - 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1928, to Dec 19, 1928, that I last saw him alive on Dec 19, 1928, and that death occurred, on the date stated above, at 3:25 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
10 1/2 (duration) yrs. mos. 1 ds.
 CONTRIBUTORY Atherosclerosis
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

Cerebral fluid
 (Signed) Owen J. H. H. M. D.
12/20, 1928. (Address) 610 N. Grand Ave.

*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

Sunset Burial Pt. 12-22 1928

20. UNDERTAKER ADDRESS

Ziegenheim Bros. 26 256 Chesker

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2

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1
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1

1

1
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1-2
1964

**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..... Registration District No. 991 File No. 43179
 Township..... Primary Registration District No. 1003 Registered No. 12485
 City St. Louis (No.....) St. Ward)

2. FULL NAME

Dolores 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

(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. FILED

FEB 11 1928

Handwritten signature and stamp

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 19-1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar pneumonia

CONTRIBUTORY (duration) yrs. mos. ds. Acidosis Non Diabetic

INFORMATION GIVEN OVER PHONE BY Dr. A. W. Nabree, M.D. of St. L.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? 2-14-29

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS? 101W

(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

19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

STATEMENT OF OCCUPATION IS VERY IMPORTANT

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