

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

Do not use this space.

2137

1. PLACE OF DEATH

County Johnson
Township Chilhowee
City..... (No.....,St.Ward)

Registration District No. 420
Primary Registration District No. 53-81

File No.....
Registered No.....

2. FULL NAME

George W Howard

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Howard

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August, 31, 1843

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>82</u>	<u>4</u>	<u>18</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).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Tennessee

10. NAME OF FATHER G. W. Howard

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. Geo W Howard

INFORMANT (Address) Chilhowee, Mo

15. Filed 1/20/29 W.H. Macher
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 18, 1929

17. I HEREBY CERTIFY That I attended deceased from July 15, 1927 to Jan 17, 1929
that I last saw him alive on Jan 16, 1929, and that death occurred, on the date stated above, at 11 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis
131 (duration) yrs. mos. da.

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

18. WHERE WAS DISEASE CONTRACTED.....
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? no DATE OF.....
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) W.H. Macher, M. D.
1/20/29 (Address) Chilhowee Mo

*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 Cornelia, Cem. DATE OF BURIAL Jan 20, 1929

20. UNDERTAKER S. Sweeney, Warrensburg, Mo ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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