

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

Do not use this space.

26734-b
40

1. PLACE OF DEATH

County Shelby Registration District No. 830-4503
Township _____ Primary Registration District No. 6091-4503
City Shelbina (No. _____) St. _____ Ward _____

2. FULL NAME

Wallace Wallace M. Howell
(a) Residence. No. Furnish Smith Hospital Ward. Shelbina Mo
(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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6/5/1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
76 | 1 | 1 | _____

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Wallace M. Howell

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

12. MAIDEN NAME OF MOTHER Mrs. Beulah Hall

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

14. INFORMANT Mrs. Guy Brooke
(Address) Shelbina Mo

15. FILED Oct 29 1929 Madge Good REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/6 1929

17. I HEREBY CERTIFY That I attended deceased from June 22 1929 to July 6 1929
that I last saw h. l. a. alive on July 6 1929, and that death occurred, on the date stated above, at _____ P. _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gangrene of right foot and leg.
59
988
(duration) yrs. mos. 14 ds.

CONTRIBUTORY Diabetes Mellitus (SECONDARY)
(duration) 10 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) W. J. Smith, M. D.
, 19 _____ (Address) Shelbina 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 Bental Cemetery DATE OF BURIAL 7/8 1929

20. UNDERTAKER Fred A. Thompson ADDRESS Madison

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

102
102
55
2
29
1
2
K. R.—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.

OCT 24 1929

