MAR 28 1930

51

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

Do not use this space.

File No. 5624

Registered No. 146

1. PLACE OF DEATH
County Livingston
Township Chillicothe
City ..... (No. ....., ... St. ..... Ward)

Registration District No. 508
Primary Registration District No. 5674

2. FULL NAME Robert J. Howe

(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: Male

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) March 26 1912

7. AGE: Years 17 | Months 11 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

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) Livingston Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER R F Howe

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

12. MAIDEN NAME OF MOTHER Elbie Burns

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

14. INFORMANT R. F. Howe
(Address) R 1 Chillicothe Mo

15. FILED 3/1 1930 Reuben Barney
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1930, to Feb 28 1930, that I last saw h. alive on 2-26 1930, and that death occurred, on the date stated above, at 10 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
7
10 d (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Measles
..... (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? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Signs
(Signed) H. D. Dowell, M. D.
2/28 1930 (Address) Chillicothe 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: Anderson Cem.
DATE OF BURIAL: Mar 2 1930

20. UNDERTAKER: F B Norman
ADDRESS: Chillicothe

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.