

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

Do not use this space.
23634-a
File No. 19
Registered No. 19
St. _____ Ward _____

1. PLACE OF DEATH
County Montgomery
Township Wrightsville
City Wrightsville (No. _____)

Registration District No. 595
Primary Registration District No. 4353

2. FULL NAME Julia Howard
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 10 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 Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Geo Howard
6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 16-1831
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
99 4 6

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. at home
(b) General nature of industry, business, or establishment in which employed (or employer). Same
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Burbon Co
(STATE OR COUNTRY) Kentucky

10. NAME OF FATHER Mont Beard
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Anna Brown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kentucky
(STATE OR COUNTRY) Kentucky

14. INFORMANT Hor Hewitt
(Address) Wellsdale Mo

15. FILED Oct 1, 1930 Mrs O. Yewett. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 21- 1930
17. I HEREBY CERTIFY, That I attended deceased from July 21- 1930
that I last saw her alive on July 21, 1930 and that death occurred, on the date stated above, at _____ m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile Debility
162
191 (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Heart protrusion
(SECONDARY) (duration) _____ yrs. _____ mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED 1914
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) R. G. Steuford M. D.
, 19 _____ (Address) Willsdale 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 Mount Carmel DATE OF BURIAL July 23, 1930

20. UNDERTAKER Chas B. Helle ADDRESS Wellsdale Mo

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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