

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

Do not use this space.

39598172

1. PLACE OF DEATH

County Jackson
Township Kaw
City K.C. Mo (No. Mr Way to Hospital)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Clyde Howard
(a) Residence. No. Brunswick Mo St. _____ Ward _____
(Usual place of abode)

Brunswick Mo
(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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
29 no record

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

9. BIRTHPLACE (CITY OR TOWN) Brunswick Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Joseph L. Howard

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

12. MAIDEN NAME OF MOTHER Flora Stewart

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

14. INFORMANT Ray Howard
(Address) Brunswick Mo

15. FILED 12/1/30 M.M. Cravel REGISTRAR
asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-27 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental Asphyxia
from
fall from
210M
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY fall on ladder
(SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Harry M. Shell M. D.
Dec. 1930 (Address) St. Louis

*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 Brunswick Mo DATE OF BURIAL Dec 26 1930

20. UNDERTAKER D.W. Newcander ADDRESS K.C. Mo.

X. 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.

