

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

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.

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

22896  
Do not use this space.

REC'D JUL 18 1939

1. PLACE OF DEATH

(a) County Peru Registration District No. 65-1  
(b) Township Peru Primary Registration District No. 9-863  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Alma Howell

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF \_\_\_\_\_ (OR) WIFE OF Carrie Howell

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-9-1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hr. or min.  
30 2 25

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. labor  
9. Industry or business in which work was done, as saw mill, bank, etc. common labor  
10. Date deceased last worked at this occupation (month and year) unknown 11. Total time (years) spent in this occupation life

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Mo

FATHER  
13. NAME Henry Howell  
14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Tenn

MOTHER  
15. MAIDEN NAME Linda Battles  
16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Tenn

17. INFORMANT (ADDRESS) Carrie Howell

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple DATE 6-5-39

19. FUNERAL DIRECTOR (NAME) H. E. Smith (ADDRESS) Carrollton Mo

20. FILED June 7 1939 Ada Martin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-4-39

22. I HEREBY CERTIFY, That I attended deceased from April 3, 1939, to Apr 3, 1939  
I last saw him alive on Apr 3, 1939. Death is said to have occurred on the date stated above, at 7:30 pm.  
The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis Date of onset \_\_\_\_\_  
Other contributory causes of importance: 72

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) P. E. Cooper, M. D.  
Coates, Mo. (Address) 585

RECEIVED

District Health Officer No. 3,

District File Number 739-2404

Date Filed 7/8/39

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**