

JUL 18 1939

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

22976  
Do not use this space.

1. PLACE OF DEATH <sup>2</sup>  
(a) County Pike Registration District No. 689  
(b) Township Buttada Primary Registration District No. 3033  
(c) City Louisiana (d) Street No. 511 Neb  
(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 Albert Howard  
(a) Residence, No. 511 Neb 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  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10/3/1879  
7. AGE YEARS MONTHS DAYS / If LESS than 1 day, ..... hrs. or ..... min.  
59 | 7 | 29  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer  
9. Industry or business in which work was done, as saw mill, bank, etc. Laborer  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....  
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisiana Mo  
13. NAME Jobe Howard  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisiana Mo  
15. MAIDEN NAME Dessie Mays  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisiana Mo  
17. INFORMANT Barbara Howard  
(ADDRESS) Louisiana Mo  
18. BURIAL, CREMATION, OR REMOVAL PLACE Riverside DATE 7/3 1939  
19. FUNERAL DIRECTOR (NAME) W. Neely  
(ADDRESS) Louisiana Mo  
20. FILED 7-1-39 Kotally Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 30 1939  
22. I HEREBY CERTIFY, That I attended deceased from ..... 19... to ..... 19...  
I last saw h..... alive on..... 19... Death is said to have occurred on the date stated above, at 10:00 P  
The principal cause of death and related causes of importance were as follows:  
Suicide.  
Cut throat with a razor  
Date of onset  
16/3  
Other contributory causes of importance:  
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? Suicide Date of injury 6/30, 1939  
Where did injury occur? at his home Louisiana Mo  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
at his home  
Manner of injury Cut throat with razor  
Nature of injury.....  
24. Was disease or injury in any way related to occupation of deceased?  
If so, specify Coroner  
(Signed) Porter Turpin  
631 (Address) Bowling Green Mo

WRITE PLAINLY, 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.

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1-51

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STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH

RECEIVED  
District Health Officer No. 10  
District File Number 7-39-1229  
Date Filed JUL 12 1939

**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.**