

1830 SEP 12 1939

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

28644
Do not use this space.

1. PLACE OF DEATH

(a) County **Buchanan** Registration District No. **85**
(b) Township _____ Primary Registration District No. **1001**
(c) City **St. Joseph** (d) Street No. **St. Joseph, Hospital** Registered No. **875**
(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 **Charles Howard**

(a) Residence, No. **807 Carby** St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **Colored** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed-?**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **9/7/1883-?**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56-? ? ?

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

12. BIRTHPLACE (CITY OR TOWN) **Unknown**
(STATE OR COUNTRY) **Unknown**

13. NAME **Unknown**

14. BIRTHPLACE (CITY OR TOWN) **Unknown**
(STATE OR COUNTRY) **Unknown**

15. MAIDEN NAME **Unknown**

16. BIRTHPLACE (CITY OR TOWN) **Unknown**
(STATE OR COUNTRY) **Unknown**

17. INFORMANT **Welfare Board Records**
(ADDRESS) **Community Hall**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **City Cemetery** DATE **8-29-'39**

19. FUNERAL DIRECTOR **Graves Funeral Home.**
(ADDRESS) **806 S. 17th, St**

20. FILED **Aug. 29, 1939 H. J. Nestlebrink**
H.B. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **8/26/'39.**

22. I HEREBY CERTIFY, That I attended deceased from **8-25**, 19**39**, to **8-26**, 19**39**
I last saw **him** alive on **8-25**, 19**39** Death is said to have occurred on the date stated above, at **2:10 A.M.**
The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset **8/21/39**
Hypertension
Other contributory causes of importance:
2000
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? **Yes**

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) **Overton Gray**, M. D.
(Address) **Dr. Gray**

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.

1 X12004

(WAS NOT EMBALMED)

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)