

1936 OCT 22 1939

Registration District No. 104

Primary Registration District No. 5151

Registrar's No. 274

1. PLACE OF DEATH: 2

(a) County Callaway  
(b) City or town Rural - The Cedric Township  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community \_\_\_\_\_ years, months or days

8. (a) PRINT FULL NAME James Howard

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Sallee Howard 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 4 1857  
(Month) (Day) (Year)

8. AGE: Years 82 Months 0 Days 23 If less than one day hr. min.

9. Birthplace Watertown New York  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

12. Name Dannick Howard

13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Rose Helen

15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Louise Howard

(b) Address McCrack, Missouri

17. (a) Burial (b) Date thereof 9-30-1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Primer's Chapel

18. (a) Signature of funeral director Geo. J. Callahan

(b) Address Fulton, Missouri

19. (a) Sept 29 1939 (b) A. N. Creswell  
(Date received local registrar) (Registrar's signature) 1012

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. McCrack Township  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27th, 1939  
year 1939 hour 9 minute 15 M.

21. I hereby certify that I attended the deceased from June 1936, 19\_\_\_\_, to Present time, 19\_\_\_\_; that I last saw him alive on Sept 27th, 1939, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac insufficiency following arteriosclerosis, Hypertension (220-100) Hemiplegia. L.  
(since May 1937)

Due to Uremic toxemia, (two weeks)

Due to \_\_\_\_\_

Other conditions Age 82 years.  
(Include pregnancy within 3 months of death)

Major findings: No operation.  
Of operations \_\_\_\_\_

Of autopsy No autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Greene D. McCall M.D. (M. D. or other) \_\_\_\_\_  
Address Fulton, Missouri Date signed 9/29/39

PHYSICIAN

Underline the cause to which death should be charged statistically.

USE OF THIS INFORMATION SHOULD BE CAREFULLY SUPPLIED TO THE BUREAU OF THE CENSUS IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED.

82d

**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..... *Geo. S. Wallace* .....

Licensed Embalmer No. *3373*

P. O. Address *Fulton mo*

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

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

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

320467  
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104  
(b) Township Enc Credie Primary Registration District No. 5757  
(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 James Howard

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
82 0 23

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
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) (STATE OR COUNTRY) \_\_\_\_\_

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-27 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 \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Cardiac Insufficiency following Arteriosclerosis Hypertension (220-100) Paralysis & pneumonia Cause unknown.  
Other contributory causes of importance: Arterio Sclerosis (Two Weeks) age 82

Date of onset

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis: none Was there an autopsy? no

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? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) Greene & McCall, M. D.

(Address) Fulton mo

UNIFORM BLANK INK—MAKE A PERMANENT RECORD  
 PROPERTY OF STATE HEALTH DEPARTMENT  
 REGISTERED EXACTLY. PHYSICIAN SHOULD BE  
 OCCUPATION  
 THEY ARE  
 IN  
 CERTIFICATES  
 A FEE FOR  
 NOT RECORDED  
 PLATE should be  
 so that it may  
 CAUSE OF DEATH in part  
 REGISTRARS SHALL NOT RECORD

SUPPLEMENT

S-32046