

Registration District No. 477

Primary Registration District No. 4286

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Canton MO
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Life years, months or days

3. (a) PRINT FULL NAME John Martica Howard

3. (b) If veteran, name war No 3. (c) Social Security No. none

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Edith Howard 6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Feb 19 1860
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 16 If less than one day hr. min.

9. Birthplace Lewis Co MO
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business 1

MOTHER FATHER
12. Name James Howard
13. Birthplace Polk Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Howard
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs John Howard

(b) Address Canton MO

17. (a) Burial (b) Date thereof 6-1-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Canton MO

18. (a) Signature of funeral director H. S. Kelly

(b) Address Canton MO

19. (a) June 30, 1940 (b) H. W. Harris MO
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lewis
(c) City or town Canton
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30 year 1940 hour 9 a.m. minute _____ M.

21. I hereby certify that I attended the deceased from 1 _____, 1934, to 6-30 _____, 1940; that I last saw him alive on 5-29 _____, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 week
Due to Myocarditis 5 yrs.

Due to _____
Other conditions Kidney infections 9 yrs.
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

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? 4:30
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Earl Porter (M.D. or other) D.V.
Address Canton MO Date signed 7/1/40

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.

73.21

RECEIVED

District Health Officer No. 10

District File No. 6-40-1146

Date Filed JUN 7 1940

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.....

W. S. Kelly

....., Registered Apprentice No.....

working under my personal supervision.

Signed *W. S. Kelly*

Licensed Embalmer No. 1953

P. O. Address *Centon, Md*

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.

o. 2B
-21-40
X22639

MOORE
WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 18882

Registration District No. 477

Primary Registration District No. 4286

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Lewis
(b) City or town Canton
(If outside city or town limits, write "RURAL" and name of 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)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John M. Howard
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

20. DATE OF DEATH month 5 day 30
year _____ hour _____ minute _____ M.

4. Sex m 5. Color or race W
6. (a) Single, widowed, married, divorced w
6. (b) Name of husband or wife _____
6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral Hemorrhage

8. AGE: Years 80 Months 3 Days 16
If less than one day _____ min.

Due to myo Carditis
Due to _____
Other conditions Kidney infection
(Include pregnancy within 3 months of death)
Chronic nephritis
Major findings:
Of operations _____
Of autopsy _____

9. Birthplace _____
(City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 Zark Porter (M. D. or other) _____
Address Canton Mo Date signed _____

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-18882