

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town Crosno
(c) Name of hospital or institution:
20 Mi. South E. of Charleston
(d) Length of stay: In hospital or institution 6 years
In this community 6 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miss.
(c) City or town Crosno
(d) Street No. 0
(e) If foreign born, how long in U. S. A.?

8. (a) PRINT FULL NAME William Arlie Howard 630

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

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

6. (b) Name of husband or wife X X X 6. (c) Age of husband or wife if alive X X years

7. Birth date of deceased Feb. 3 1933
(Month) (Day) (Year)

8. AGE: Years 7 Months 3 Days 5 If less than one day hr. min.

9. Birthplace Oran Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation school boy

11. Industry or business X X X

12. Name John R. Howard
13. Birthplace Cape County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Sadie Young
15. Birthplace Lake City Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant John R. Howard
(b) Address Crosno, Mo.

17. (a) Burial (b) Date thereof 5-9-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleston, Mo.

18. (a) Signature of funeral director Lair-Nunnelee Service

(b) Address Charleston, Mo.

19. (a) 5-10-40 (b) F. D. Vernon
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8
year 1940 hour 11 minute 20 P. M.

21. I hereby certify that I attended the deceased from June 24th 1940 to May 8th 1940
that I last saw him alive on May 24th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to

Due to

Other conditions: 108
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of 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 C. C. Presnell (M. D. or other)

Address Charleston, Mo. Date signed

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

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 2

District File Number 640-109

Date Filed 6/5/40

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.