DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JUL 17 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22066

Registration District No. 5586 Primary Registration District No. 4256 Registrar's No. 430

1. PLACE OF DEATH:
(a) County Johnson
(b) City or town Rural Post Oak Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Post Oak Twp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

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

3. (a) PRINT FULL NAME John Samuel Howe
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex M
5. Color or race Wh
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary McGirl Howe
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased Feb. (Month) 26 (Day) 1861 (Year)

8. AGE: Years 79 Months 3 Days 24 If less than one day ..... hr. ..... min.

9. Birthplace Johnson Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business .....
FATHER
12. Name John F. Howe
13. Birthplace Penn. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Rachel Grandstaff
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant's own signature W. J. Niles
(b) Address Leeton Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Greer Cem. Johnson Co. Mo.
18. (a) Signature of funeral director W. J. Niles
(b) Address Warrensburg Mo.
19. (a) July 6, 1946 (Date received by local registrar) (b) Annabel Reynolds (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20 year 1946 hour 8 minute 30 A.M.
21. I hereby certify that I attended the deceased from Dec 1939 ....., 19..., to June 20 ....., 1946 that I last saw him alive on June 20 ....., 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration
Due to .....
Due to .....
Other conditions (Include pregnancy within 3 months of death) .....
Major findings: Of operations .....
Of autopsy None

PHYSICIAN — 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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature R. Lee Porter (M. D. or other) M.D.
Address Warrensburg Mo. Date signed 6-21-46

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4-16-40

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. 3653

P. O. Address Warrensburg Mo.

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

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