

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

25723

State File No. \_\_\_\_\_

Registration District No. 548

Primary Registration District No. 4323

Registrar's No. 37

1. PLACE OF DEATH:  
(a) County Palmyra Marion Co.  
(b) City or town Palmyra Mo.  
(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 49 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Marion  
(c) City or town Palmyra Mo.  
(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 ROSA ISABELA HOWARD 630  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife H. M. Howard 6. (c) Age of husband as wife died 76 years  
7. Birth date of deceased AUG 24 1860  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>10</u>	<u>16</u>	____ hr. ____ min.

9. Birthplace Cincinnati Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name Casper Brumm  
13. Birthplace Not Known  
(City, town, or county) (State or foreign country)  
14. Maiden name Not Known  
15. Birthplace Not Known  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rosa S. Howard  
(b) Address Elkins W. Va.

17. (a) Interment & Cremation (b) Date thereof July 13 - 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Valhalla Cemetery, St. Louis Mo.

18. (a) Signature of funeral director E. S. Snaque  
(b) Address Palmyra Mo.

19. (a) July 11 - 1940 (b) Gertrude Lee  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 10  
year 1940 hour 2 minute 45 A.M.  
21. I hereby certify that I attended the deceased from 6/15  
1940, to 7/10, 1940  
that I last saw her alive on 7/9, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Artemia  
auricular fibrillation  
Due to Hypertensive heart disease  
Due to \_\_\_\_\_

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

Other conditions \_\_\_\_\_  
(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? Yes

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature W. J. Hill (M. D. or other) MD  
Address Palmyra Mo. Date signed 7/11/40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

9-10-22

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**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.....

Carl Abbott....., Registered Apprentice No. 229  
working under my personal supervision.

Signed E. J. Sprague  
Licensed Embalmer No. 3245  
P. O. Address Palmyra Mo

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **25-723**

Registration District No. **548**

Primary Registration District No. **4323**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Palmyra**  
(b) City or town **Palmyra**  
(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) (Specify whether

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

**Rosa Isabela Howard**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex **F**

5. Color or race **w**

6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE:

Years **79** Months **10** Days **16**

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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 \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar)

(b) \_\_\_\_\_ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **7** day **10** year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death **cerebral arteriosclerosis fibrillation**  
**Hypertensive heart**  
**Chronic nephritis**

Duration

**1 mo.**

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature **J. W. Well** (M. D. or other)

Address **Palmyra** Date signed \_\_\_\_\_

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

SUPPLEMENTAL 1940

