

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

28365
Do not use this space.

FILED AUG 23 1940

SEP 19 1940

1. PLACE OF DEATH
 (a) County Crawford Registration District No. 1113
 (b) Township Keage Primary Registration District No. 5-219 Registered No. 12
 or City Cherryville Mo
 (c) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 Gilbert Howdshell
 (a) Residence, No. Cherryville Mo St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-22-1940

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
			<u>1</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none

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) Cherryville Mo
Crawford County

FATHER 13. NAME Elden Howdshell
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Crawford County Mo

MOTHER 15. MAIDEN NAME Rosie Powell
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Crawford County Mo

17. INFORMANT Elden Howdshell
(ADDRESS) Cherryville Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Green Date June 24 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. E. Felt
Cherryville Mo

20. FILED 7-16 1940 E. E. Felt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 23 1940

22. I HEREBY CERTIFY That I attended deceased from June 23, 1940, to _____, 19____
 (last saw h. in alive on June 23, 1940) Death is said to have occurred on the date stated above, at 6 a.m.
 The principal cause of death and related causes of importance were as follows:
congenital heart disease
 Date of onset _____

Other contributory causes of importance: 15A ✓
inattention

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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) Willard H. Ray, D.O.
211 (Address) Steelville, Mo.

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 840 887

Date Filed _____

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 Henry M. Jones

Licensed Embalmer No. 2628

P. O. Address Steckville, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28365-**

Registration District No. **1113**

Primary Registration District No. **5317**

Registrar's No. **12**

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

1. PLACE OF DEATH:
 (a) County Crawford
 (b) City or town Osage
(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, days

3. (a) PRINT FULL NAME James Gilbert Howe Shelb
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex m **5. Color or race** w
6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife _____
6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased 6 22 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months 1 Days _____
 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
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) 7-16-48 **(b)** E. E. Shelb
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION
20. DATE OF DEATH month June day 23
 year _____ hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
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 _____ (M. D. or other)
Address _____ **Date signed** _____

SUPPLEMENTAL

