

FILED JAN 8 1941
399

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4681

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
H. C. General Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 17 days
 In this community 1926
(Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM HOWES

3. (b) If veteran, name war No 3. (c) Social Security No. No

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

6. (b) Name of husband or wife Esther Beeler Howes 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased February 8 1883
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>10</u>	<u>0</u>	<u>hr. min.</u>

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

10. Usual occupation Salesman

11. Industry or business J. R. Watkins Company

12. Name Howes

13. Birthplace No record
(City, town, or county) (State or foreign country)

14. Maiden names Jane Luers

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Esther Howes

(b) Address 2753 Charlotte

17. (a) Burial (b) Date thereof Dec 10, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director John P. Shell

(b) Address 6606 Indap Ave

19. (a) 12-9-40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 2753 Charlotte
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 8th
year 1940 hour 2 minute 40 A. M.

21. I hereby certify that I attended the deceased from 11-21-40, 19____, to 12-8-40, 19____; that I last saw h in alive on 12-8-40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death
BRONCHIAL ASTHMA, BRONCHIECTASIS
EMPHYSEMA

Due to _____
Due to _____

Other conditions CEREBRAL EDEMA AND CONGESTION
(Include pregnancy within 3 months of death)

Major findings:
- Of operations _____
Of autopsy See above

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) (Means of injury)
23. Signature Dr. K. J. General (M. D. or other) _____
Address Med. Dir. K. J. General Hospital State signed _____

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

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

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, fact should be so stated above.