No. 2
4-13-40
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X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 14 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5926

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 698

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: St. Mary's Hospital, (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks, (Specify whether

In this community 30 years, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Jackson, 47

(c) City or town Kansas City, (If outside city or town limits, write "RURAL")

(d) Street No. 1016 Locust, Drake Hotel, (If rural, give location)

(e) If foreign born, how long in U. S. A.? no. 0 years.

3. (a) PRINT FULL NAME Mrs. Elizabeth Helm Howard,

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed,

6. (b) Name of husband or wife James A. Howard,

6. (c) Age of husband or wife if alive dec. years

7. Birth date of deceased Unknown, (Month) (Day) (Year)

8. AGE: Years 82 Months Days If less than one day hr. min.

9. Birthplace Missouri, (City, town, or county) 0 (State or foreign country)

10. Usual occupation at home,

11. Industry or business x

FATHER
12. Name James A. Helm,
13. Birthplace Kentucky, (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Warren,
15. Birthplace Kentucky, (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Thomas Costolow,

(b) Address 4937 Mercier, Kansas City, Mo.

17. (a) Removal, (Burial, cremation, or removal) (b) Date thereof 2-18-41 (Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs, Mo.,

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K.C., Mo.

19. (a) 2/17/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 16th year 1941 hour 1:00 minute P. M.

21. I hereby certify that I attended the deceased from Dec 4, 1941, to Feb 16, 1941; that I last saw her alive on Feb 15, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Encephalo Malaria	6 mos
Chronic Myocarditis	years
Chronic Bronchitis	"
Due to Cardio-vascular hypertension	years
Due to & General Arterio-sclerosis	years

Other conditions (Include pregnancy within 3 months of death) 92A

Major findings: Of operations None

Of autopsy 93A

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

22. If death was due to external causes, fill in the following: No

(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 0

23. Signature Marvin L. Bills, M.D. (M. D. or other)

Address 1424 Prof. Bldg. K.C. Mo. Date signed 7-II-41

(Licensed Embalmer's Statement on Reverse Side)

Dr. M. L. Bills,
1 to 4 Proff. Bldg.

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 [signature]

Licensed Embalmer No. 1415

P. O. Address 17, C. Mo.

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

If this body is not embalmed, fact should be so stated above.