

S. No. 2
4-1-441
7. 5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MADE MAY 14 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6018**
790
Registrar's No.

Registration District No. **399** Primary Registration District No. **1002**

48
25
8
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Kansas City T. B. Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 mo 23 days**
(Specify whether years, months or days)
In this community **13 years**

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. **220 1/2 Walnut**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **John Howard**
(b) If veteran, name war **no**
(c) Social Security No. **no**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **2** day **21**
year **41** hour **6** minute **20 P.M.**
21. I hereby certify that I attended the deceased from **3-29-40** to **2-21** 19**41**
that I last saw him alive on **2-21** 19**41**
and that death occurred on the date and hour stated above.

4. Sex **male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **wid.**
(b) Name of husband or wife **Cora Howard**
(c) Age of husband or wife if alive **10 1/2** years
7. Birth date of deceased **Aug. 10 1892**
(Month) (Day) (Year)

Immediate cause of death **pulmonary tuberculosis**
Due to **13 1/2**
Due to **10 1/2**
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy
Duration
Underline the cause to which death should be charged statistically.

8. AGE: Years **48** Months **6** Days **11** If less than one day hr. min.
9. Birthplace **Kentucky** (City, town, or county) (State or foreign country) **1**
10. Usual occupation **none**

MOTHER FATHER
11. Industry or business
12. Name **John Howard**
13. Birthplace **Kentucky** (City, town, or county) (State or foreign country) **1**
14. Maiden name **Cynthia M. Howell**
15. Birthplace **Kentucky** (City, town, or county) (State or foreign country) **1**
16. (a) Informant **K. C. M. T. B. Hospital**
(b) Address **Leeds - Leavenworth**
17. (a) **burial** (b) Date thereof **Feb. 25 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt Washington**
18. (a) Signature of funeral director **Mrs. C. L. Foster**
(b) Address **918 Brooklyn**
19. (a) **2/24/41** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

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? Means of injury **0**
23. Signature **[Signature]** (M. D. or other)
Address **C. T. Hospital** Date signed **2/24/41**

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 Me

....., Registered Apprentice No.....
working under my personal supervision.

Signed J. C. Law Sheppard

Licensed Embalmer No. 41719

P. O. Address K. C. Wis.

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.