

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28768
Registrar's No. 72

FILLED SEP 25 1941
496
Registration District No. 496

Primary Registration District No. 3025

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(c) Name of hospital or institution: McLarney
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks
In this community 54 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn
(c) City or town Westville
(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.? 0 years.

3. (a) PRINT FULL NAME EDWARD WEST HOWARD

3. (b) If veteran, name war World War 3. (c) Social Security No. None

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Anna Oldham Howard 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased January 30 1887
(Month) (Day) (Year)

8. AGE: Years 54 Months 8 Days 3 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name George W. Howard
13. Birthplace Lagonda Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Jessie West
15. Birthplace Westville Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Anna Howard
(b) Address Marceline, Mo

17. (a) Burial (b) Date thereof Sept - 6 - 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bell Cemetery

18. (a) Signature of funeral director James Maughler
(b) Address Marceline, Mo

19. (a) 9/4/41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 3
year 1941 hour 2 minute 45 p.m.

21. I hereby certify that I attended the deceased from 7-2x, 1941, to 9-3, 1941.
that I last saw him alive on 9-3, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial infarction Duration 10 hrs

Due to Perforation - Intestinal Obstruction - Gall Trichela
Due to Gangrene Appendix 40 hrs

Other conditions 0 (Include pregnancy within 3 months of death) 12/11

Major findings: Intestinal obstruction following Perforation from Gang. Appendix
Of autopsy 0

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) 0
(b) Date of occurrence 0
(c) Where did injury occur? 0 (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0
While at work? 0 (Specify type of place) (e) Means of injury 0

23. Signature [Signature] (M. D. or other) [Signature]
Address Brookfield Mo Date signed 9/4

OCT 6 1941

SEP 24 1941

DEC 23 1941

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 *Blanche M. Langhorne*

Licensed Embalmer No.....1909.....

P. O. Address *Marceline 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.