

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.

FILED SEP 19 1941

Registration District No. 614

Primary Registration District No. 5816

1. PLACE OF DEATH:
 (a) County Newton
 (b) City or town Rural Granby
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: None
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution One Year (Specify whether
 In this community One Year years, months or days)

3. (a) PRINT FULL NAME Susan Jane Howes
 8. (b) If veteran, name war --- 8. (c) Social Security No. ---

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Benjam H. Howes 6. (c) Age of husband or wife if alive --- years
 7. Birth date of deceased May 6 1865
 (Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days 25 If less than one day hr. min.

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

10. Usual occupation ---

11. Industry or business Not Known

MOTHER FATHER { 12. Name Not Known
 13. Birthplace Not Known (City, town, or county) (State or foreign country)

{ 14. Maiden name Not Known
 15. Birthplace Not Known (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Earn Howes
 (b) Address Stark City R#

17. (a) Burial (b) Date thereof Aug. 3-4
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation I. O. O. F. Newtonia

18. (a) Signature of funeral director W. J. Rales
 (b) Address Wheaton MO.

19. (a) Aug 2 1941 (b) W. J. Rales
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Newton
 (c) City or town Rural
 (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 August day 2
 year 1941 hour 2 minute 20 A. M.
 21. I hereby certify that I attended the deceased from Oct. 15 - 1940
 to Aug 2 1941;
 that I last saw her alive on Aug 1 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency Duration 6 mo
 Due to ---
 Due to ---
 Other conditions --- (Includes pregnancy within 3 months of death)
 Major findings: ---
 Of operations ---
 Of autopsy ---

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?
 While at work? (Specify type of place) (e) Means of injury ---

23. Signature W. J. Rales (M. D. or other) ---
 Address Granby Date signed 8-2-41

RECEIVED

District Health Officer No. 6,

District File Number 941-1518

Date Filed SEP 16 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 Wm. Morris Toomey

Licensed Embalmer No. 38472

P. O. Address Wheeler 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.