

No. 2  
4-13-40  
-17-39  
I X23159

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

JAN 16 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42331

Registrar's No. 87

Registration District No. 461

Primary Registration District No. 3024

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

1. PLACE OF DEATH *Lafayette*

(a) County *Lafayette*

(b) City or town *Luxington Mo*

(c) Name of hospital or institution *5th st.*

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *Life* (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MO* (b) County *Lafayette*

(c) City or town *Luxington*

(d) Street No. *5th st.* (If rural, give location)

(e) If foreign born, how long in U. S. A. *0* years.

3. (a) PRINT FULL NAME *Herbert Howard*

3. (b) If veteran, name war *-*

3. (c) Social Security No. *-*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec*, day *27*, year *1941* hour *6* minute *A* M.

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *SO*

6. (b) Name of husband or wife *-* 6. (c) Age of husband or wife if alive *-* years (Day) (Year)

7. Birth date of deceased *July 23 1934*

21. I hereby certify that I attended the deceased from *Dec 20*, 1941, to *Dec 26*, 1941; that I last saw him alive on *Dec 26*, 1941, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<i>7</i>	<i>5</i>	<i>4</i>	hr. min.

Immediate cause of death *Bronchial pneumonia - 1 week failure*

9. Birthplace *Luxington Ohio* (City, town, or county) (State or foreign country)

10. Usual occupation *School*

Due to *-*

Due to *-*

Other conditions *-* (include pregnancy within 3 months of death)

11. Industry or business *-*

12. Name *Herbert Howard*

13. Birthplace *Luxington Ohio* (City, town, or county) (State or foreign country)

14. Maiden name *Ethel Johnson*

15. Birthplace *Lodge Ohio* (City, town, or county) (State or foreign country)

Major findings: *-*

Of operations *-*

Of autopsy *-*

PHYSICIAN *-*

Underline the cause to which death should be charged statistically.

16. (a) Informant *Herbert Howard*

(b) Address *Luxington Mo*

17. (a) *Burial* (b) Date thereof *12-29-41* (Month) (Day) (Year)

(c) Place: burial or cremation *Luxington, Mo*

18. (a) Signature of funeral director *Wendell*

(b) Address *Luxington Mo*

19. (a) *12-29-41* (Date received local registrar) (b) *Welia Tate* (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? *-*

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

23. Signature *B. H. Brasher M.D.* (M. D. or other) *0*

Address *Luxington Mo* Date signed *-7-82*

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 1-14-42

**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 Geo. A. McKeon

Licensed Embalmer No. 2983

P. O. Address Leungton Dr

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 42331

Registration District No. 461

Primary Registration District No. 3024

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Lebanon  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Herbert Howard

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased July 23 1941  
(Month) (Day) (Year)

8. AGE: Years 7 Months 5 Days no.  
(If less than one day min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day \_\_\_\_\_ Year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Heart Failure  
Bronchial pneumonia

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)  
(2) Means of injury

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed 1-31-42

SUPPLEMENTARY

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

MOTHER FATHER

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

