

FILED MAR 8 1943

State File No.

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 20

1. PLACE OF DEATH:

(a) County HOWELL

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

(c) Name of hospital or institution: WEST PLAINS HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)

In this community 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State NONE (b) County 46

(c) City or town 5
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME HUBERT EVERETT McDOWELL

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced INFANT

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

7. Birth date of deceased JANUARY 10, 1943
(Month) (Day) (Year)

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

0 0 1 hr. min.

9. Birthplace WEST PLAINS, MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business

MOTHER FATHER

12. Name EVERETT MCDOWELL

13. Birthplace KINGFISHER CO., OKLA.
(City, town, or county) (State or foreign country)

14. Maiden name LOIS MCFARLAND

15. Birthplace DOUGLAS CO., MO.
(City, town, or county) (State or foreign country)

16. (a) Informant EVERETT MCDOWELL
(b) Address WEST PLAINS, MO. RT. 3.

17. (a) BURIAL (b) Date thereof JAN 20 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation HOWELL VALLEY CEM., HOWELL TWP, HOWELL Co., Mo.

18. (a) Signature of funeral director H. J. Thompson
(b) Address WEST PLAINS, MO.

19. (a) 2-10-43 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

21. I hereby certify that I attended the deceased from 19....., to 19.....; that I last saw h..... alive on 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Failure

Due to 7 mo Premature

Due to 159

Other conditions (Include pregnancy within 3 months of death) 159

Major findings: Of operations Of autopsy

Duration

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? X

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

23. Signature Manuel Shaylor (M. D. or other) MD
Address West Plains Mo Date signed 1/27/40

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

RECEIVED

District Health

District File Number

Officer No. 51
343129
3-3-43

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.

Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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. 6513
Registrar's No. _____

Registration District No. _____

Primary Registration District No. 3025

1. PLACE OF DEATH:

(a) County Howell

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

(c) Name of hospital or institution: West Plains Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 ds
(Specify whether years, months or days)

In this community 1 ds

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Howell

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

(d) Street No. Peace Valley R 1
(If rural, give location)

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

3. (a) PRINT FULL NAME Hubert E McHowell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 15 Year 1943 Hour _____ Minute _____

21. I hereby certify that I attended the deceased from 7/19/1919 to 7/19/1943 that I last saw him alive on 7/19/1943 and that death occurred on the date and hour stated above.

Immediate cause of death _____

4. Sex _____ 5. Color or race _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months _____ Days _____ if less than one day _____ min.

9. Birthplace: (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or 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) (Burial, cremation, or removal) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

Duration _____

Other conditions _____ (Include 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) _____

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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



