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No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **2180**

Registration District No. **149**

Primary Registration District No. **1002**

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:
2921 Linwood Blvd. Gen Hosp. (1)
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **None 1 day**
(Specify whether)

In this community **20 years**
years, months or days

3. (a) PRINT FULL NAME **William G. HOWSE.**

3. (b) If veteran, name war **World War #2**

3. (c) Social Security No. **495-05-0137**

4. Sex **Male (1)**

5. Color or race **White**

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **July 7th 1915**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	27	10	1	hr. min.

9. Birthplace **Pittsburg Pennsylvania**
(City, town, or county) (State or foreign country)

10. Usual occupation **U.S. Army (3 Months)**

11. Industry or business _____

MOTHER FATHER { 12. Name **Edward G. Howse.**

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

14. Maiden name **Cathryn McGowan**

15. Birthplace **Pittsburg Pennsylvania**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. E. G. Howse.**

(b) Address **2921 Linwood Blvd.**

17. (a) **Burial** (b) Date thereof **5/5/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Mary's Cemetery**

18. (a) Signature of funeral director **Mellody-McGilley**

(b) Address **K. C. Mo.**

19. (a) **5-11-43** (b) **m m. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson 48**

(c) City or town **Kansas City Mo. 3**
(If outside city or town limits, write "RURAL")

(d) Street No. **2921 Linwood Blvd. 8**
(If rural, give location) **0**

(e) Citizen of foreign country? **No.** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **May** day **8**
year **1943** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____ 19____;
that I last saw h **Deputy Coroner** 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Gunshot wound of abdomen and chest.** Duration _____

Due to _____

Due to _____ **184**

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

Major findings: Of operations _____

Of autopsy **See Above**

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) **Accident 123**

(b) Date of occurrence **May 7, 1943**

(c) Where did injury occur **Kansas City Jackson Mo.**
(City or town) (County) (State)

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

While at work? **No** (Specify type of place)

23. Signature **D. E. Usher** (M. D. or other) **M.D.**
Address **23rd McCoy** Date signed **5/8/43**

KANSAS CITY, MO. 64108

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 Russell France
Licensed Embalmer No. 4255
P. O. Address KC 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2180

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(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 _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME William S. House

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

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) _____ (b) Date thereof 5-12-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-11-43 (b) M. M. Crowe
(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 _____ Day _____ Year _____ Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

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)

(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 _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

16979