

FILED JUN 2 1943  
Registration District No. 307

Primary Registration District No. 6049

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St Charles  
(b) City or town DePue Rural  
(c) Name of hospital or institution Jennie Orage Trp  
(If outside city or town limits, write "RURAL" and name of township)  
(d) Length of stay: In hospital or institution, write street number or location  
(Specify whether In this community, 2 years years, months or days)

3. (a) PRINT FULL NAME Elvira Howell

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

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

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

7. Birth date of deceased march 22 1855  
(Month) (Day) (Year)

8. AGE: Years 88 Months 1 Days 9 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace St Charles Co - O  
(City, town, or county) (State or foreign country)

10. Usual occupation housework

11. Industry or business

12. Name John Johnson  
13. Birthplace East River O  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Stevenson  
15. Birthplace dark river O  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Marion Howell

(b) Address DePue Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6 1943  
(Month) (Day) (Year)

(c) Place: burial or cremation DePue

18. (a) Signature of funeral director Marion Howell

(b) Address Windsorville Mo

19. (a) May 6 1943 (b) Calvin Clayton  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Charles  
(c) City or town DePue  
(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 May day 2  
year 1943 hour 57 minute 30p M.

21. I hereby certify that I attended the deceased from May 1  
\_\_\_\_\_ 19 43, to May 2 19 43  
that I last saw her alive on May 2 19 43  
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris  
Coronary thrombosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 94 lb

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?  
\_\_\_\_\_

23. Signature Calvin Clayton (M. D. or other) M.D.  
Address Angnota Mo Date signed 5/6/43

Duration

2 days  
2 days

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING 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.

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**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 \_\_\_\_\_

Licensed Embalmer No. 2451

P. O. Address Wentzville

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 307

Primary Registration District No. 6049

Registrar's No. ....

1. PLACE OF DEATH:

(a) County St Charles  
(b) City or town Fremont Osage, Mo  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St Charles  
(c) City or town MATSON (RURAL)  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Elvira Howell

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

4. Sex F 5. Color and race W 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 March 2, 1902  
(Month) (Day) (Year)

8. AGE: Years 88 Months \_\_\_\_\_ Days \_\_\_\_\_ (if less than one day \_\_\_\_\_ min.)

9. Birthplace St Charles, Mo  
(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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

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

**SUPPLEMENTARY**

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 \_\_\_\_\_ 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

MOTHER FATHER

5-18874