DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 22 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

21952

State File No.

Registration District No. 109

Primary Registration District No. 3043

Registrar's No. 139

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

1. PLACE OF DEATH:
(a) County: Marion
(b) City or town: Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Levering Hospital
(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 .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Marion
(c) City or town: Hanhibal
(If outside city or town limits, write "RURAL")
(d) Street No.: 1228 Hill
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Elizabeth B Howell

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: Widowed

6. (b) Name of husband or wife: John S.Howell

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

7. Birth date of deceased: October 31, 1866 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
76	6	15	..... hr. ..... min.

9. Birthplace: Troy Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation: XX

11. Industry or business: XX

FATHER
12. Name: Henry Walton Perkins
13. Birthplace: Lincoln County Missouri (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name: Elizabeth B.Perkins
15. Birthplace: Virginia (City, town, or county) (State or foreign country)

16. (a) Informant: John Martin
(b) Address: 1228 Hill

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/18/43 (Month) (Day) (Year)
(c) Place: burial or cremation: Mount Olivet

18. (a) Signature of funeral director: Wm M Smith
(b) Address: Hannibal Missouri

19. (a) 5/17/43 (Date received by local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 year 1943 hour 3 minute OOP. M.

21. I hereby certify that I attended the deceased from 1 ....., 1930, to 5-15-1943, that I last saw h. alive on 5-15-1943, and that death occurred on the date and hour stated above.

Immediate cause of death: Brain Tumor — Duration: 3 weeks

Due to .....

Due to .....

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)
(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: [illegible] (M. D. or other)
Address: Hannibal Mo Date signed 5-17-43

1146

(Licensed Embalmer's Statement on Reverse Side)

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 George T. Bond, Registered Apprentice No. 150, working under my personal supervision.

Signed Wm M. Smith

Licensed Embalmer No. 1204

P. O. Address Hannibal Missouri

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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 139

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(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 ..... (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 .....

3. (a) PRINT FULL NAME Elizabeth B. Howell

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 W

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

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

7. Birth date of deceased Oct (Month) 31 (Day) 1866 (Year)

8. AGE: Years 76 Months 6 Days 3 If less than one day ..... hr. ..... min.

9. Birthplace Tay (City, town, or county) Mo. (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 15
year 1943 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 Brain Tumor

Due to .....

Due to Kind of tumor unknown

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

Major findings:
Of operations .....
Of autopsy 57d

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature [signature] (M. D. or other)

Address Hannibal Mo. Date signed 6-28-43

5-21952