

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 13 1943
Registration District No. 1572/9

Primary Registration District No. 1002

Registrar's No. 4195

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

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: Conley Clinical Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)

In this community 2 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 6711 East 17th St.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT MRS. ETHEL GEORGIA HOWARD
FULL NAME

3. (b) If veteran, name war XX

3. (c) Social Security No. No

4. Sex Fe 5. Color or race Wh

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

6. (b) Name of husband or wife Charles Nelson Howard

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

7. Birth date of deceased March 1 1872
(Month) (Day) (Year)

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

71 7 0 hr. min.

9. Birthplace Sigourney IOWA
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name John B. Wisna

13. Birthplace Sigourney, Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Ann Jane Ford

15. Birthplace Sigourney, Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Roy John Jarrett

(b) Address 3521 Lexington

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-2-43
(Month) (Day) (Year)

(c) Place: burial or cremation Oakland, Arkansas

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) 10-2-43 (b) Dep. P. C. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 1st

year 1943 hour 3: minute 20 P. M.

21. I hereby certify that I attended the deceased from Sept 12
1943 to October 1st, 1943

that I last saw him alive on October 1st, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Complete cardiac and respiratory failure

Due to Chronic myocarditis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 93

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 Chas. Plavny (Specify type of place) (City or town) (County) (State) Mo.

Address Chamberlains Bldg Date signed 10-2-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

HM 100004
Kearney Co
HT 2515

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..... *Cecil R. Matthes*

Licensed Embalmer No. *3807*

P. O. Address. *Kansas City, 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.