

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield

(c) Name of hospital or institution 1017 WEST WEBSTER  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 year (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County GREENE

(c) City or town SPRINGFIELD

(d) Street No. 1017 WEST WEBSTER  
(If rural, give location)

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

3. (a) PRINT FULL NAME WILEY LEWIS HOWARD

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22  
year 1943 hour 4:00 minute P. M.

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

21. I hereby certify that I attended the deceased from Dec 10 1943 to Dec 22 1943  
that I last saw him 1m alive on Dec 22 1943  
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife DORA M. HOWARD 6. (c) Age of husband or wife if alive Club years 9 1874

7. Birth date of deceased NOV (Month) 9 (Day) 1874 (Year)

Immediate cause of death Coronary Heart Thrombosis  
arteriosclerosis

Duration 18 years

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>71</u>	<u>1</u>	<u>13</u>	hr. <u>0</u> min. <u>0</u>

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace AVA. MO 0  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 18/a

10. Usual occupation COOK

Major findings: Of operations \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name THOMAS HOWARD

13. Birthplace AVA. MO 0  
(City, town, or county) (State or foreign country)

14. Maiden name AKA. LEWIS

15. Birthplace ASHBROVE MO 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Martha Cummings

(b) Address 1017 WEST WEBSTER, Spfld., MO.

17. (a) REMOVAL (b) Date thereof 12 22 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GOOD HOPE, MO

18. (a) Signature of funeral director CHANNING BEARD FUNERAL HOME

(b) Address AVA MO

19. (a) 12-23-43 (b) W. H. Handley  
(Date received local registrar) (Registrar's signature)

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)

23. Signature W. H. Handley (M. D. or other) MD

Address Springfield, MO Date signed 12-22-43

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

9  
2  
6

**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..... *W. B. Witham* .....

Licensed Embalmer No..... *3431* .....

P. O. Address..... *Am 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.**