

No. 2
-2-43
-17-39
X3969

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42927
Registrar's No. 104

Registration District No. 100

Primary Registration District No. 2725

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

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Rural "Hudson" Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Hilbert Catholic Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

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

(d) Street No. 208 1/2 W Coates
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME ARLENE HOWELL

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 16th
year 1943 hour 7:55 minute A. M.

4. Sex Female 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 Aug 9th 1920
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from November 12, 1943 to November 16th, 1943
that I last saw her alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebro spinal syphilis

Duration Over 5 weeks

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

23 2 7 _____ hr. _____ min.

Due to _____

Due to _____

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

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

10. Usual occupation At home

Major findings: Of operations _____

11. Industry or business _____

12. Name Clyde Howell

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

13. Birthplace _____ (City, town, or county) (State or foreign country) Mo O

14. Maiden name Mattie L. Wright

15. Birthplace _____ (City, town, or county) (State or foreign country) Mo O

16. (a) Informant Clyde Howell

(b) Address Moberly Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 18th 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Moberly Mo

18. (a) Signature of funeral director Mahawandson

(b) Address _____

19. (a) 11/30/43 (Date received local registrar) (b) Jora B. Hummel (Registrar's signature)

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 Philip S. Pendergast (M-D or other) Do

Address Macon, Missouri Date signed 11/16/43

RECEIVED

District Health Officer Hca 10

District Health Officer Hca 10
12-4-3-2012

Date Filed **DEC 15 1949**

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 Albert Skinner
Licensed Embalmer No. 75-1
P. O. Address Macon 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.