

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8662

X26390

Registration District No. 19244

Primary Registration District No. 6273 4347

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Worth

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

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

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

In this community 30 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Worth 113

(c) City or town Grant City, Mo.
(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 Anna Howell

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 15
year 1944 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from 1-2
1944 to 1-15 1944
that I last saw her alive on 1-15 1944
and that death occurred on the date and hour stated above.

4. Sex W 5. Color or race W 6. (a) Single, widowed, married 2 divorced

6. (b) Name of husband or wife Mose Howell 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 20 1855
(Month) (Day) (Year)

Immediate cause of death Pneumonia (Lobar) Duration 4 days

8. AGE: Years 88 Months 0 Days 25 If less than one day _____ hr. _____ min.

Due to _____

Due to _____

9. Birthplace Davenport Iowa
(City, town, or county) (State or foreign country)

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

Major findings: ✓
Of operations ✓

10. Usual occupation Housewife

Of autopsy no

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business no

12. Name Samuel Batman

13. Birthplace Shubertown Pa
(City, town, or county) (State or foreign country)

14. Maiden name Katie Mosley

15. Birthplace Shubertown Pa
(City, town, or county) (State or foreign country)

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?

16. (a) Informant Mrs. Zeb Porter

(b) Address Grant City, Mo.

While at work? ✓ (Specify type of place) (e). Means of injury ✓

17. (a) Burial (b) Date thereof 1-16-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation at home

23. Signature [Signature] (M. D. or other) _____
Address Grant City Mo Date signed 1-16-44

18. (a) Signature of funeral director [Signature]

(b) Address Grant City, Mo.

19. (a) 1-22-44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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 Josh C. Dunfee
Licensed Embalmer No. 3252
P. O. Address Grant 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.