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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 19 1944

Registration District No. 217

Primary Registration District No. 4329

Registrar's No. 68

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town Wyatt
(c) Name of hospital or institution:
1 1/2 Mile West
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 Years
In this community 17 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Miss.
(c) City or town Wyatt
1 1/2 Mile West
(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 None

3. (a) PRINT FULL NAME Joshua Howell

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

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

6. (b) Name of husband or wife Anna Jane Howell 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased January 8th 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace Perry Co. Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name Frank Howell

13. Birthplace Perry Co. Ind.
(City, town, or county) (State or foreign country)

14. Maiden name Molly Mock

15. Birthplace Perry Co. Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Jane Howell
(b) Address Wyatt, Mo.

17. (a) Burial (b) Date thereof 9-23-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery, Charleston, Mo.

18. (a) Signature of funeral director: [Signature]
(b) Address Charleston, Mo.

19. (a) 10/1/44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 21st
year 1944 hour 6 minute 50 P. M.

21. I hereby certify that I attended the deceased from Sept 19 1944 to Sept 21 1944
that I last saw him alive on Sept 21 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis
Due to _____

Due to _____
Other conditions (Include pregnancy within 3 months of death) 9/4/44

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? _____

While at work _____ (Specify type of place)
(b) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address Charleston, Mo. Date signed 9/25/44

Duration

9/19/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

700

RECEIVED

District Health Office No. 2,

District File Number 1044-1426

Date Filed 10-18-44

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

John F. Rimmelle Jr

Licensed Embalmer No. 3851

P. O. Address Charleston 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.