

FILED DEC 18 1944

Registration District No. **199**

Primary Registration District No. **4289**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Hawk Point Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location) 1

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

In this community _____ years, months or days

3. (a) PRINT FULL NAME WILLIAM B HOWELL

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

4. Male 5. Color or race White 6. (a) Single, widowed, married, divorced 9

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

7. Birth date of deceased May 31 1858
(Month) (Day) (Year)

8. AGE: Years 86 Months 5 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Hawk Point Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Robert Howell

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

14. Maiden name Princess

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

16. (a) Informant Alma Howell

(b) Address Hawk Point Mo

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Wm. Jackson

(b) Address Liberty Mo

19. (a) Nov 15-44 (b) Mrs. Wm. Jackson
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lincoln 57
(c) City or town Hawk Point Mo
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25
year _____ hour 4 P minute _____ M.

21. I hereby certify that I attended the deceased from _____
19 22 to Oct 25 19 44

that I last saw him alive on Oct 25 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Artery Disease Duration _____

Due to Generalized arteriosclerosis

Due to _____

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

Major findings: Of operations _____

Of autopsy Yes

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) (e) Means of injury _____

23. Signature J. Lebeck (M. D. or other) _____

Address Troy Mo Date signed Oct 27

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

57
0
0

FEB 1 1945

RECEIVED

District Health Officer No. 9;

District File Number

Date Filed 12-16-44

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 *Marie Munday*

Licensed Embalmer No. 2461

P. O. Address *Wentzville*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 410-02

Registration District No. 179

Primary Registration District No. 4289

Registrar's No.

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Hausk Point
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether

3. (a) PRINT FULL NAME Wm B. Howell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

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

7. Birth date of deceased May 21
(Month) (Day) (Year)

8. AGE: Years 86 Months 5 Days 10 If less than one day, _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) March 13/1948 (b) Pauline M. Jager
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

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) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

SUPPLEMENTARY

