. S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 3 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

5190

State File No.

Registration District No. 149 Primary Registration District No. 1002. Registrar's No. 744

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: K.C. TB. Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days (Specify whether

In this community 26 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 48

(d) Street No. 523 Grand (If rural, give location) 7

(e) Citizen of foreign country? No. (Yes or No) 8

If yes, name country

3. (a) PRINT FULL NAME James J. Howard

3. (b) If veteran, name war no

3. (c) Social Security No. 496-01-5246

4. Sex M

5. Color or race W

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 November (Month) 4 (Day) 1884 (Year)

8. AGE: Years 60 Months 2 Days 28 If less than one day hr. min.

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

10. Usual occupation Construction Worker

11. Industry or business

FATHER
12. Name John Howard
13. Birthplace (City, town, or county) Ireland (State or foreign country) 4

MOTHER
14. Maiden name Mary Thomas
15. Birthplace (City, town, or county) Ireland (State or foreign country) 4

16. (a) Informant Records K.C. TB. Hospital

(b) Address K.C. 3 Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/45 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Calvery Cem

18. (a) Signature of funeral director Snow-Mayberry

(b) Address 2315 Linwood

19. (a) 2-14-45 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 2 year 1945 hour 2-30 minute A. M.

21. I hereby certify that I attended the deceased from 1-18-45, 19, to 2-2-45; that I last saw him alive on 2-2, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	1 yr.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 13 b	

Major findings:
Of operations
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Matthew J. Noon (M. D. or other)

Address K.C. TB. Hosp. Date signed 2/5/45

(Licensed Embalmer's Statement on Reverse Side)

Bill Lohmeyer
G. H. #1,

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.....Roy E Snow

Licensed Embalmer No.....2560

P. O. Address.....K C 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.