S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 16 1945

Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

8890

State File No.

Primary Registration District No. 5018

Registrar's No. 23

1. PLACE OF DEATH:
(a) County Andrew
(b) City or town Platte Twp Rural
(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 years, months or days)
In this community 26 yrs.

2. USUAL RESIDENCE OF DEACESED:
(a) State Missouri (b) County Andrew
(c) City or town Platte Twp 2
(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 Martha Jane Howard
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced W 2
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 5 (Month) 15 (Day) 1869 (Year)

8. AGE: Years 76 Months 8 Days 27 If less than one day hr. min.

9. Birthplace Whitesville (City, town, or county) Mo 1 (State or foreign country)
10. Usual occupation At home
11. Industry or business
MOTHER FATHER
12. Name Joseph Ogle
13. Birthplace Andrew Co (City, town, or county) Mo 1 (State or foreign country)
14. Maiden name Kate Aee
15. Birthplace Whitesville (City, town, or county) Mo 1 (State or foreign country)
16. (a) Informant Mrs. Marie Heffaker
(b) Address Savannah Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Whitesville yes
18. (a) Signature of funeral director E. B. Crist
(b) Address Savannah Mo
19. (a) 3-1-45 (Date received local registrar) (b) F H Fritchman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 27 year 1945 hour 11 minute p. M.
21. I hereby certify that I attended the deceased from 2-9, 1945 to 2-27, 1945 that I last saw her alive on 2-25, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomia of Stomach

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 Dr. E. M. Reynolds (M. D. or other)
Address Union Star Mo Date signed 2-28-45

1072 (Licensed Embalmer's Statement on Reverse Side)

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 E. C. Brect

Licensed Embalmer No. 2650

P. O. Address Savannah Ms

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.