

State File No. _____
Registrar's No. _____

Registration District No. H Primary Registration District No. 5023

1. PLACE OF DEATH:
 (a) County ATCHISON
 (b) City or town RURAL, CLAY TWP.
(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

2. USUAL RESIDENCE OF DECEASED:
 (a) State COLORADO (b) County 999
 (c) City or town GREELEY 5
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location) 0
 (e) Citizen of foreign country? _____
(Yes or No) 2
 If yes, name country _____

3. (a) PRINT FULL NAME JESSIE LEOTA HOWELL
 (b) If veteran, name war ✓
 (c) Social Security No. ✓

4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced MARRIED
 (b) Name of husband or wife E.L. HOWELL
 (c) Age of husband or wife if alive 75 years
 7. Birth date of deceased 6 (Month) 17 (Day) 1878 (Year)

8. AGE: Years 67 Months 4 Days 23
 If less than one day _____ hr. _____ min.

9. Birthplace HOMER OHIO
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business HOUSEWIFE

MOTHER { 12. Name C.V. VAN RHODEN
 13. Birthplace UNKNOWN OHIO
(City, town, or county) (State or foreign country)

14. Maiden name STOUT
 15. Birthplace UNKNOWN Ia.
(City, town, or county) (State or foreign country)

16. (a) Informant J. A. HOWELL
 (b) Address ROCK PORT, MO

17. (a) REMOVAL (b) Date thereof 10-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation GREELEY COLO

18. (a) Signature of funeral director BART HOLMEW MORTUARY
 (b) Address ROCK PORT, MO

19. (a) Oct 31-1945 (b) Beth Crabtree
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 30 year 1945 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from Sept. 10 1945 to Oct. 30 1945 that I last saw him alive on Oct. 29 1945 and that death occurred on the date and hour stated above.

Immediate cause of death M.I. -
Carditis, Chronic
 Due to Emphysema 2.700
 Due to Pneumonia 4.000
 Other conditions _____
(Include pregnancy within 3 months of death)

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

Major findings: Of operations _____
 Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)
 (r) Means of injury 0

23. Signature A. A. Reel (M. D. or Other) _____
 Address _____ Date signed 10/30/45

1077

Reel

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

APR 12 1953

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 *J. Barntson*

Licensed Embalmer No. 3173
P. O. Address Rock Point, Md

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.

Registration District No. 4 Primary Registration District No. 5023

1. PLACE OF DEATH:
(a) County Atchison
(b) City or town Rural Clayburg
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Jessie L. Howell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 17 (Month) (Day) (Year)

8. AGE: Years 67 Months 4 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (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 _____ Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 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 Tuberc pleuronia

Other conditions _____ (Include 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 11/2/1915

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

Duration
10 4
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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