

S. No. 2
M-2-43
7-5-17-39
V1 X35697

FILED FEB 11 1946

Registration District No. _____ Primary Registration District No. **3000** Registrar's No. **45**

1. PLACE OF DEATH:
 (a) County **Adair**
 (b) City or town **Kirksville**
(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) **40 yrs.**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **Adair**
 (c) City or town **Kirksville Mo.**
(If outside city or town limits, write "RURAL")
 (d) Street No. **307 N. Franklin**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **William Alice Howell**
3. (b) If veteran. **3. (c) Social Security**
 name war _____ No.
4. Sex **Female** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced**
6. (b) Name of husband or wife **S. J. Howell** **6. (c) Age of husband or wife if alive** **69** years
7. Birth date of deceased **June 12, 1876**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan** day **29**
 year **1946** hour **11:30 AM** minute _____ M.
21. I hereby certify that I attended the deceased from **Sept. 20**, 19**45**, to **Jan. 29**, 19**46**
 that I last saw her alive on **Jan. 29**, 19**46**
 and that death occurred on the date and hour stated above.

8. AGE: Years **70** Months **7** Days **17** If less than one day _____ hr. _____ min.
9. Birthplace **Salisbury MO**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

Immediate cause of death _____
 Due to **Cardio Vascular Renal Disease**
 Due to **Chronic Nephritis**
 Other conditions _____
(Include pregnancy within 3 months of death)

MOTHER FATHER
11. Industry or business _____
12. Name **Zachary Tate**
13. Birthplace **Fairbault NY**
(City, town, or county) (State or foreign country)
14. Maiden name **Meliga M. Warren**
15. Birthplace **Apron Ohio**
(City, town, or county) (State or foreign country)

Major findings:
 Of operations **12/15**
 Of autopsy _____
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **S. J. Howell**
(b) Address **Kirksville, Mo.**
17. (a) **Burial** **(b) Date thereof** **2-1-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Burial Oakwood Cmt**
18. (a) Signature of funeral director **Adams Funeral Home**
(b) Address **Kirksville, Mo.**
19. (a) **2-4-46** **(b)** **Kate Lambert**
(Date received from registrar) (Registrar's signature)

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) (e) Means of injury
23. Signature **C. A. Adams** (M.D. or other) **P.O.**
Address **104 1/2 N. Franklin** **Kirksville Mo** **Date signed** **Feb 6**

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

001

161
82-11-46

2-46-228

2-8-1946

FEB 18 1946

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..... *Bowden Bosty*
Licensed Embalmer No. *4379*
P. O. Address..... *Hicksville, 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.