DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 12 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27175

Registration District No. 14 Primary Registration District No. 1002 Registrar's No. 3449

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: St Joseph Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month (Specify whether years, months or days) In this community 1 Month

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Rush 979
(c) City or town LaCrosse (If outside city or town limits, write "RURAL") 14
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME Myrtle Marion Howell
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Earl Howell
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased March 11, 1897 (Month) (Day) (Year)
8. AGE: Years 49 Months 4 Days 29 If less than one day hr. min.
9. Birthplace Unknown (City, town, or county) Virginia (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name Milton Marion Moore
13. Birthplace Unknown (City, town, or county) W. Virg. (State or foreign country)
MOTHER 14. Maiden name Ida Mae Huse
15. Birthplace Unknown (City, town, or county) W. Virg. (State or foreign country)
16. (a) Informant Earl Howell
(b) Address LaCrosse. Kan.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-11-46 (Month) (Day) (Year)
(c) Place: burial or cremation LaCrosse, Kan.
18. (a) Signature of funeral director Mellody-McGilley-Eylar
(b) Address Kansas City, Mo.
19. (a) 8-10-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 10 th year 1946 hour 2 minute 10 P.M.
21. I hereby certify that I attended the deceased from 10 July 1946, to 10 Aug 1946, that I last saw alive on 10 Aug 46, 19..., and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Encephalomalacia	
Due to: Pending further Investigation	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: Above	
Of autopsy: Above	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 0
23. Signature [illegible] (M.D. or other)
Address St Joseph Hosp Date signed 12 Aug 46

(Licensed Embalmer's Statement on Reverse Side)

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

-5-43
-17-39
X36671

APR 2 1947

JUL 7 1961

DEC 4 1948

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 Glen E. Heck

Licensed Embalmer No. 4063

P. O. Address Kansas City, 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.

BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. 3449

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. ~~3419~~

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:
(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

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

3. (a) PRINT FULL NAME Myrtle Marion Howell
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex
5. Color or race
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 8-10-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 10 year 1946 hour 2 minute 10P. M.
21. I hereby certify that I attended the deceased from July 10, 1946 to 8-10 1946 that I last saw her alive on 8-10 1946 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Cerebral encephalomalacia
Due to malignant tumor of brain (type undetermined)
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 5-46
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 Russell W. Kerr (M. D. ~~or other~~)
Address St. Joseph Hosp. Date signed 8-10-46

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3420

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County .....

(b) City or town .....
(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 .....

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 .....

3. (a) PRINT FULL NAME .....

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex .....

5. Color or race .....

6. (a) Single, widowed, married, divorced .....

6. (b) Name of husband or wife .....

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

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

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

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

10. Usual occupation .....

11. Industry or business .....

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

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

16. (a) Informant .....
(b) Address .....

17. (a) .....
(Burial, cremation, or removal)
(b) Date thereof .....
(Month) (Day) (Year)
(c) Place: burial or cremation .....

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

19. (a) .....
(Date received local registrar)
(b) .....
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day .....
year ..... hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from .....
....., 19....., to ....., 19.....;
that I last saw h..... alive on ....., 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions ..... (Include pregnancy within 3 months of death)	

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 ..... (M. D. or other) .....
Address ..... Date signed .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.