V. S. No. 2
0M—8-43
ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 8 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

29714

State File No.

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 321

14
1
2

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

1. PLACE OF DEATH:

(a) County Calloway

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

(c) Name of hospital or institution 2 State Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 Y 4M 5d (Specify whether years, months or days)

In this community 10 Y 4M 5d

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon 14

(c) City or town Macon 1
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Charles Howard

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 2

5. Color or race N

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 (Month) (Day) (Year) 1883

8. AGE: Years 63 about Months Days If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business

FATHER
12. Name DK 9
13. Birthplace DK (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name DK 9
15. Birthplace DK (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Fulton, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 1st 1946 (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo

18. (a) Signature of funeral director Glen Y. Manpin

(b) Address 712 Court St. Fulton Mo.

19. (a) Oct 1st 1946 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25 year 1946 hour 2 a. M.

21. I hereby certify that I attended the deceased from 5-1- 1942 to 9-25- 1946 that I last saw him alive on 9-24- 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to

Due to Generalized arteriosclerosis

Other conditions Hypertension
(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy none

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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 P. J. Tate for Forest Thomas (M. D. or other)

Address State Hosp. # 1 - 7 Fulton Date signed 9-28-46

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 10-17-46

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. C. Rossow

Licensed Embalmer No. 2555

P. O. Address.....

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.