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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 13 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41663

Registration District No. 270

Primary Registration District No. 4428

Registrar's No. 118

1. PLACE OF DEATH:
(a) County Pulaski
(b) City or town Richland
(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 Mo (b) County Pulaski
(c) City or town Richland
(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 WESLIE HOWELL
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 19 day 1946 year hour 11 minute 30 a.m.

4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Oma Howell
6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased April 2 1878
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 22 1946 to Feb 22 1947
that I last saw him alive on Dec 22 1946
and that death occurred on the date and hour stated above.
Immediate cause of death respiration
Duration _____

8. AGE: Years 68 Months 7 Days 17 If less than one day hr. _____ min. _____

Due to natural causes
Due to _____

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

Other conditions: _____
(Include pregnancy within 3 months of death)

10. Usual occupation Farmer

11. Industry or business _____

Major findings: Of operations _____
Of autopsy _____

12. Name William A Howell

13. Birthplace Palto Co Mo (City, town, or county) (State or foreign country)

14. Maiden name Minnie Kalford

15. Birthplace unknown Tennessee (City, town, or county) (State or foreign country)

16. (a) Informant Alf Howell

(b) Address Rural Richland Mo

17. (a) Burial (b) Date thereof Dec 22-46 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn

18. (a) Signature of funeral director R B Serpe

(b) Address Richland Mo

19. (a) 1-2-47 (b) Lennie B McClintock (Date received local 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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature L. J. M. J. (M. D. or other) D. O.
Address Richland Mo Date signed 12/22/46

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

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

MOTHER FATHER

351

(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.....

R. B. Jurek

Licensed Embalmer No. *3148*

P. O. Address. *Richland, W. Va.*

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. 290

Primary Registration District No. 4428

1. PLACE OF DEATH: Pulaski
 (a) County Pulaski
 (b) City or town Richland
 (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 Weslie Howell
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 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 _____

7. Birth date of deceased April 2
 (Month) (Day) (Year)

8. AGE: 68 Years Months Days If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (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) 1-2-47 (Date received local registrar) (b) Louise B. McClintock (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 Dec Day _____ Year 1946 Hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
 that I last saw him _____ after on _____ 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to _____
 Due to _____
 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 _____

SUPPLEMENTARY

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

MOTHER FATHER

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

41663