

Registration District No. **211**

Primary Registration District No. **4456**

Registrar's No. **23**

1. PLACE OF DEATH: **St Clair**  
(a) County **St Clair**  
(b) City or town **Appleton city**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Home**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **32 yrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **St Clair**  
(c) City or town **Appleton city**  
(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 **D. Mike Howard**  
3. (b) If veteran, name war **None**  
3. (c) Social Security No. **None**

20. DATE OF DEATH: Month **Dec** day **13** year **1946** hour **9** minute **30 A.** M.  
21. I hereby certify that I attended the deceased from **13 Dec 1946** to **13 Dec 1946** that I last saw him alive on **13 Dec 1946** and that death occurred on the date and hour stated above.

4. Sex **male** 5. Color or race **white**  
6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Dorothy Nation**  
6. (c) Age of husband or wife if alive **3** years  
7. Birth date of deceased **June 3 1881**  
(Month) (Day) (Year)

Immediate cause of death **Coronary thrombosis**  
Duration \_\_\_\_\_

8. AGE: Years **65** Months **6** Days **10** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace **Mo** (City, town, or county) (State or foreign country)  
10. Usual occupation **Veterinary**

Major findings: Of operations **94X**

11. Industry or business **Doctoring Domestic Animals**  
12. Name **Henry M. Howard**  
13. Birthplace **Mo** (City, town, or county) (State or foreign country)  
14. Maiden name **Sarah Suiter**  
15. Birthplace **Ark** (City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant **Dorothy Howard**  
(b) Address **Appleton city Mo**  
17. (a) **Burial** (b) Date thereof **12 17 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Appleton city cem**  
18. (a) Signature of funeral director **Frank Lee**  
(b) Address **Appleton city Mo**  
19. (a) **Dec 16 46** (b) **Mr. C. H. Huey**  
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature **W. H. Lee** (M. D. or other) **Mr**  
Address **Appleton city** Date signed **16 Dec 46**

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

MOTHER FATHER

97-82-21  
6718-97-11

JAN 9 1947

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

on the 13<sup>th</sup> day of Dec 1946, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Frank Lee

Licensed Embalmer No. 1099

P. O. Address Appleton 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. 23

Registration District No. 311

Primary Registration District No. 4456

1. PLACE OF DEATH:  
(a) County St Clair  
(b) City or town Appleton 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 \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME D. Mike Howard  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color of race W  
6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased: June 3 (Month) (Day) (Year)

8. AGE: 65 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) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(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 MO (b) County St Clair  
(c) City or town Appleton City (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 14 Year \_\_\_\_\_ Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 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? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

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

MOTHER FATHER

41783