

**FILED APR 1 1947**  
Registration District No. **33**

Primary Registration District No. **3010**

Registrar's No. **95**

**1. PLACE OF DEATH:**

(a) County **Cape Girardeau**  
(b) City or town **Cape Girardeau**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **St Francis Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **6 Weeks**  
(Specify whether years, months or days) **Life**

3. (a) PRINT FULL NAME **Maria Louise Howard**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **No.**

4. Sex **F.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **S.**

6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **May 28 1865**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>81</b>	<b>9</b>	<b>22</b>	hr. min.

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

10. Usual occupation **None**

11. Industry or business **None**

MOTHER FATHER

12. Name **James H. Howard**

13. Birthplace **Unk. Ky.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Byrane**  
15. Birthplace **New Madrid, Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ann Howard**

(b) Address **New Madrid, Mo.**

17. (a) **Burial** (b) Date thereof **3-21-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Howard Cemetary Ric ards Und. Co.**

18. (a) Signature of funeral director **New Madrid, Mo.**

(b) Address **3-26-1947** (b) **C. C. Summers**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo.** (b) County **New Madrid**  
(c) City or town **New Madrid**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **City**  
(If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country **No.**

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **March** day **19**  
year **1947** hour **9** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **1-23**, 19**47**, to **3-19**, 19**47**  
that I last saw **her** alive on **3/9/47**, 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumo**  
Due to **F. R. Hemar**

Due to **Pneumo**  
Other conditions **Pneumo**  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations  
Of autopsy  
**1947 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide **Accident**  
(b) Date of occurrence **3/23/47**  
(c) Where did injury occur? **Home**  
(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 **C. C. Summers** (M. D. or other)  
Address **Cape Girardeau** Date signed **3/24/47**

RECEIVED

District Health Officer No. 4  
District File Number 347-446  
Date Filed 3-31-47

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. Collins*  
Licensed Embalmer No. 4346  
P. O. Address New Madrid

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 8179  
Registrar's No. 95

Registration District No. \_\_\_\_\_ Primary Registration District No. 3010

1. PLACE OF DEATH:  
(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(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 Maria L. Howard  
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 81 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (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 March year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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) Acc.

(b) Date of occurrence 3-17-47

(c) Where did injury occur? Home - Paul Marie (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Carl Theodore (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed 4/10/48

SUPPLEMENTARY

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

J-8179