S. No. 2
OM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 12 1947

STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

Mrs Howe

State File No. 12418

Registration District No. 31 Primary Registration District No. 5107 Registrar's No. 17

**1. PLACE OF DEATH:**

(a) County BENTON
(b) City or town IONIA - White Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community LIFE
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County BENTON 8
(c) City or town IONIA 0
(If outside city or town limits, write "RURAL")
(d) Street No. — — 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME SARAH ETTIE HOWE
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced WID
6. (b) Name of husband or wife GEO W.
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 2 (Month) 3 (Day) 1868 (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 2 | 21 | hr. min. |

9. Birthplace (City, town, or county) MO 0 (State or foreign country)
10. Usual occupation AT HOME
11. Industry or business
FATHER
12. Name JNO D GREEN
13. Birthplace UNK. (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name "
15. Birthplace " (City, town, or county) 9 (State or foreign country)
16. (a) Informant JEWELL HOWE
(b) Address IONIA, MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-26-47 (Month) (Day) (Year)
(c) Place: burial or cremation MEM. PARK
18. (a) Signature of funeral director Geo Dillard
(b) Address Sedalia, Mo.
19. (a) May 5 1947 (Date received local registrar) (b) Pauline Harms (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Apr day 24 year 1947 hour 9 minute 35 M.
21. I hereby certify that I attended the deceased from 4-15- 1947, to 4-24- 1947 that I last saw her alive on 4-24- 1947 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Broken hip | |
| Due to Fall | |
| 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) accident 0
(b) Date of occurrence 4-15-1947 0
(c) Where did injury occur? Ionia Benton Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home (Specify type of place)
While at work? (e) Means of injury Fall 0
23. Signature [signature] (M. D. or other) MD
Address Cole Camp, Mo Date signed 4-24-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7A
District File Number 4-47-553
Date Filed 5-9-47

## 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 John G. Cantlon

Licensed Embalmer No. 4387

P. O. Address Sedalia, N.C.

**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.**