

S. No. 2
FORM-5-43
Rev. 5-17-39
P I X36871

FILED AUG 6 1947

Registration District No. **154**

Primary Registration District No. **5575**

Registrar's No. **24**

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
103rd and Pendergast Rd.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 72yrs

3. (a) PRINT FULL NAME John Howell

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex Male **5. Color or race** Wh

6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased May 12 1857
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>90</u>	<u>2</u>	<u>10</u>	hr. _____ min. _____

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

10. Usual occupation Farmer Retired

11. Industry or business _____

MOTHER FATHER

12. Name Richard Howell

13. Birthplace Kings County Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Susan Walsh

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

16. (a) Informant Mrs. Nona McClaster

(b) Address 103rd and Pendergast Rd.

17. (a) Removal Removal **(b) Date thereof** July 23 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stanley Kansas

18. (a) Signature of funeral director [Signature]

(b) Address Kansas City Mo

19. (a) Date received July 23-47 **(b) Registrar's signature** [Signature]
(Local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Dallace, Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 103rd and Pendergast Rd.
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 22
year 1947 hour 10¹⁰ minute 0 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Coronary sclerosis

Due to arterio sclerosis

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____
Healing of 9 inguinal

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 [Signature] (M. D. or other) _____

Address 1424 W. 11th **Date signed** 7-23-47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

Richard Roe

Licensed Embalmer No. *2810*

P. O. Address *K. 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.