

No. 2
-5-43
5-17-39
K36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36935**

FILED NOV 19 1947

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Adair**

(b) City or town **Richsville**

(c) Name of hospital or institution **Community Home # 24**
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution **16 months**
(If not in hospital or institution, write street number or location)

In this community **Community Home # 24**
years, months or days **entire life**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO**

(b) County **Scotland**

(c) City or town **Memphis 99**
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location) **0**

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Ida F. Howard**

(b) If veteran, name war **✓**

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **10**
year **1947** hour **11** minute **27 A.** M.

21. I hereby certify that I attended the deceased from **Feb 6**
19**47**, to **Nov 10** 19**47**;
that I last saw her alive on **Nov 10** 19**47**;
and that death occurred on the date and hour stated above.

4. Sex **F**

5. Color or race **w**

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

6. (b) Name of husband or wife **Douglas F. Howard**

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Nov 10 1869**
(Month) (Day) (Year)

Immediate cause of death **Coronary heart failure** Duration **18 hrs.**

Due to **Myocardial weakness** years

Due to **Rheumatic heart disease** years

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

8. AGE: Years **78** Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **Scotland Co. Mo**
(City, town, or county) (State or foreign country)

Major findings: **95B**

Of operations _____

Of autopsy _____

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

10. Usual occupation **House wife**

11. Industry or business _____

12. Name **William Hendricks**

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

14. Maiden name **Margaret Adams**

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

16. (a) Informant **Wille M. Horton**

(b) Address **977 E. Cankarras Colo. Springs Colo.**

17. (a) **Burial** (b) Date thereof **Nov 12 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Pleasant Valley**

18. (a) Signature of funeral director **Walter T. Barker**

(b) Address **Memphis Mo**

19. (a) **11-13-47** (b) **Wate Lambert**
(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) Intoxication _____

(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) _____

While at work? _____ (e) Means of injury **20**

23. Signature **M. T. Putnam** (M.D. or other) **MD**
Address **Richsville, Mo** Date signed **11-10-47**

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

RECEIVED
District Health Officer No. 17
District File Number 47-167
Date Filed NOV 18 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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed *Fred Gerth*

Licensed Embalmer No. *4256*

P. O. Address *Memphis*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. DecRegistration District No. 1Primary Registration District No. 3000

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Adair
 (b) City or town Perthville
 (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 Ida F - Howard

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

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

7. Birth date of deceased
- Nov-10
-
- (Month) (Day) (Year)

8. AGE: Years
- 78
- Months _____ Days _____ (If less than one day, hr. _____ min. _____)

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

10. Usual occupation _____

11. Industry or business _____

- MOTHER FATHER { 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) _____ (b) Date thereof _____
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

13. (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 _____

- (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 _____
-
- year
- 1947
- hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

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) _____

- (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 _____

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

SUPPLEMENTARY

S-36935