No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAY 4 1948
Registration District No. 378

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3060

State File No. 13782
Registrar's No. 123

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Farmington Mo.
(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 510 West Liberty (Specify whether)
In this community 76 Yrs 10 Months 25 Days
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Francois 94
(c) City or town Farmington 4
(If outside city or town limits, write "RURAL")
(d) Street No. 510 West Liberty /
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Annie May Howell
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Female /
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife J.D. Howell
6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased 5 (Month) 23 (Day) 1871 (Year)

8. AGE: Years 76 Months 10 Days 25 If less than one day ..... hr. ..... min.

9. Birthplace Delassus Mo. (City, town, or county) 0 (State or foreign country)
10. Usual occupation House Wife
11. Industry or business
FATHER
12. Name John Wescoat
13. Birthplace Ripley, Tenn. (City, town, or county) / (State or foreign country)
MOTHER
14. Maiden name Mary Jane Porter
15. Birthplace Ripley, Tenn (City, town, or county) / (State or foreign country)
16. (a) Informant C.A. Howell
(b) Address Ironton Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 - 21 - 48 (Month) (Day) (Year)
(c) Place: burial or cremation Parkview Cem, Farmington Mo.
18. (a) Signature of funeral director C.A. Howell
(b) Address Ironton Mo.
19. (a) 4-27-48 (Date received local registrar) (b) Esther Rudloff (Registrar's signature) 28

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18
year 1948 hour 3 minute 15A M.
21. I hereby certify that I attended the deceased from Feb 1, 1948, to April 18, 1948
that I last saw her alive on April 17, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Heart Failure	3 da
Due to Carcinoma of abdomen	8 mo.
Due to —	
Other conditions (Include pregnancy within 3 months of death) —	
Major findings: Of operations —	
Of autopsy —	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature Dr. Geo. L. Wilkins M. D. ~~or other~~
Address Farmington Mo. Date signed 4-24-48

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

...ct Health Officer No. 4

File Number 548-15

5-3-4

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 C. A. Frozen

Licensed Embalmer No. 4084

P. O. Address Farmington

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.

No. 2B
—3-45
P I X43883

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 376 Primary Registration District No. 3060 Registrar's No. 123

1. PLACE OF DEATH:

(a) County St Francois

(b) City or town Farmington (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 years, months or days) In this community

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

3. (a) PRINT FULL NAME Annie M. Howell

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased May 23 1878 (Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 18 year 1948 hour minute 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

Due to Chr abdominal pain, vomiting & respiration ended by effort. Also vomited blood & passed blood by rectum - but refused Hospitalization

Due to

Other conditions (Include pregnancy within 3 months of death) Diag exploration.

Major findings: I don't know where

Of operations Hospitalized + could specialists only

Of autopsy no autopsy permitted

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature O. Reg. L. Wathen (M. D. or other)

Address Farmington Mo Date signed 5-13-48

SUPPLEMENTARY

S-1378 2