

FILED SEP 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26300

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 389 PRIMARY REG. DIST. NO. 5761 Registrar's No. 13

|   |                               |   |                                    |
|---|-------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Callaway (Cedar Twp)</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>  |                                    |
| b. CITY OR TOWN <u>Rural 2 mi NW</u>  |                               | c. CITY OR TOWN <u>2 mi NW New Bloomfield</u>   |                                    |
| c. LENGTH OF STAY (in this place) <u>50</u>   |                               | d. STREET ADDRESS (If rural, give location) <u>3</u>  |                                    |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>probable</u>   |                               |   |                                    |
| 3. NAME OF DECEASED<br>a. (First) <u>William</u> b. (Middle) <u>MARION</u> c. (Last) <u>Howard</u>  |                               | 4. DATE OF DEATH (Month) (Day) (Year) <u>AUG 28-49</u>  |                                    |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>   | 8. DATE OF BIRTH <u>AUG 5-1875</u> |
| 9. AGE (In years last birthday) <u>74</u> Months <u>0</u> Days <u>23</u>  |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>   |                                    |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>  |                               | 11. BIRTHPLACE (State or foreign country) <u>Green County Illinois</u>  |                                    |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |                               |   |                                    |
| 13a. FATHER'S NAME <u>William H. Howard</u>   |                               | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Barrow</u>   |                                    |
| 14. NAME OF HUSBAND OR WIFE <u>Ethyl Howard</u>   |                               |   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>  |                               | 16. SOCIAL SECURITY NO. <u>NO</u>   |                                    |
| 17. INFORMANT'S SIGNATURE OR NAME <u>Miss E. M. Howard</u>  |                               | ADDRESS <u>New Bloomfield</u>   |                                    |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                               |                               | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>vascular heart disease</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><br><u>HIX</u> |                                    |
| 19a. DATE OF OPERATION  |                               | 19b. MAJOR FINDINGS OF OPERATION  |                                    |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |   |                                    |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)  |                               | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    |
| 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)   |                               |   |                                    |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug 28 1949</u>  |                               | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                    |
| 21f. HOW DID INJURY OCCUR?  |                               |   |                                    |
| 22. I hereby certify that I attended the deceased from <u>July 1</u> , 1949, to <u>Aug 28</u> , 1949, that I last saw the deceased alive on <u>Aug 27</u> , 1949, and that death occurred at <u>8 A. m.</u> , from the causes and on the date stated above. |                               |   |                                    |
| 23a. SIGNATURE <u>E. M. Prunk M.D.</u> (Degree or title)  |                               | 23b. ADDRESS <u>New Bloomfield Mo</u>   |                                    |
| 23c. DATE SIGNED <u>Aug 28-49</u>   |                               |   |                                    |
| 24a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>  |                               | 24b. DATE <u>Aug-30-49</u>  |                                    |
| 24c. NAME OF CEMETERY OR CREMATORY <u>High Fork Cemetery</u>  |                               | 24d. LOCATION (City, town, or county) (State) <u>5 mi West Guthrie Mo</u>   |                                    |
| DATE REC'D BY LOCAL REG. <u>Aug 28-49</u>   |                               | REGISTRAR'S SIGNATURE <u>Leroy Claypool</u> 39  |                                    |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>Loet - Claypool</u>   |                               | ADDRESS <u>See Me B. Mo</u>   |                                    |

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

RECEIVED SEP 10 1949  
District Health Officer No. 9,  
District File Number.....

**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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Le Roy Clapp  
Licensed Embalmer No. 4412

P. O. Address New Blenheim, Mo.

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.