

FILED DEC 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40389

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>410</u>	
1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Fulton</u>		c. LENGTH OF STAY (in this place) <u>1</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Fulton Missouri</u>		d. STREET ADDRESS (If rural, give location) <u>817 Westminster St</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>817 Westminster St</u>				d. STREET ADDRESS (If rural, give location) <u>817 Westminster St</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ELIZA</u>		b. (Middle) _____		c. (Last) <u>Howe</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 20 49</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed 2</u>		8. DATE OF BIRTH <u>Oct 20 1870</u>	
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min _____		11. BIRTHPLACE (State or foreign country) <u>Callaway Co. 0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Dave Cave</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Reece</u>		14. NAME OF HUSBAND OR WIFE <u>John Howe</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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Nathaniel Garbison Fulton Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of rectosigmoid</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>6 months</u> <u>154X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma rectosigmoid (at Ellen Fischel Hospital) Aug 48</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Fulton Callaway Mo</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>47</u> , to <u>Dec</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>20 May, 1949</u> , and that death occurred at <u>5-30 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>E. Rutledge, MD</u>				23b. ADDRESS <u>Fulton, Mo</u>		23c. DATE SIGNED <u>20 Dec 49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Dec 22-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Cave Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>2 1/2 Miles South Davis Mo</u>	
DATE REC'D BY LOCAL REG. <u>Dec 20-1949</u>		REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>		426		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kelt-Clayton Rev. Nat'l Hospital Mo</u>	

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

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RECEIVED DEC 27 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.....

Leroy Claypool

Licensed Embalmer No. *4412*

P. O. Address *New Bloomfield 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.