

FILED APR 7 1950

STANDARD CERTIFICATE OF DEATH

State File No. 9647

BIRTH NO. 16138-50 REG. DIST. NO. 210 PRIMARY REG. DIST. NO. 4322 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <b>Mercer</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Mercer</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Princeton</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Ravanna, Mo</b>	
c. LENGTH OF STAY (In this place) <b>19 days</b>		d. STREET ADDRESS (If rural, give location) <b>Lambert Hospital</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Jerry</b>	b. (Middle) <b>Dale</b>	c. (Last) <b>Howard</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>3-25-50</b>
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>( )</b>	8. DATE OF BIRTH <b>3-6-1950</b>	9. AGE (In years last birthday) <b>19</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>no</b>	11. BIRTHPLACE (State or foreign country) <b>Ravanna, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Frank D. Howard</b>	13b. MOTHER'S MAIDEN NAME <b>Ada Anderson</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Frank D. Howard</b> ADDRESS <b>Ravanna, Mo</b>
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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) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>76 30</b>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Malnutrition Infant Asphyxia</b>		<b>2 weeks</b> <b>1 week</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 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)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **March 22, 1950**, to **March 25, 1950**, that I last saw the deceased alive on **March 25, 1950**, and that death occurred at **2:45 AM.**, from the causes and on the date stated above.

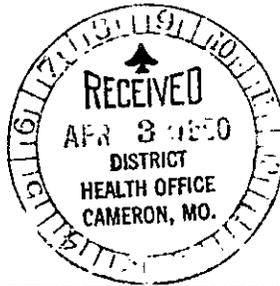
23a. SIGNATURE <b>Marian Lambert MD</b> (Degree or title)	23b. ADDRESS <b>Princeton, Mo</b>	23c. DATE SIGNED <b>3/26/50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>3-26-50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lucerne</b>	24d. LOCATION (City, town, or county) (State) <b>Lucerne, Mo</b>
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DATE REC'D BY LOCAL REG. <b>3-28-50</b>	REGISTRAR'S SIGNATURE <b>M. J. Ruth</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Noel Moss</b> ADDRESS <b>Princeton, Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0650



**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.....

.....  
working under my personal supervision.

Student Embalmer No. ....

Signed.....

*Paul Moss*

Signed.....

Student Embalmer

Licensed Embalmer No. *2634*

P. O. Address *Sumner, 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.