

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3254**
Registrar's No. **0095**

FILED JAN 28 1953

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY Fayette	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CITY OF ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Farina 8120	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			
3. NAME OF DECEASED (Type or Print) a. (First) HARRY b. (Middle) A. c. (Last) HOWELL			4. DATE OF DEATH (Month) (Day) (Year) 1 4 53
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 66		10. KIND OF BUSINESS OR INDUSTRY Ford Dealer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ford Dealer		11. BIRTHPLACE (City and State or Foreign Country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Hulda Howell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT'S SIGNATURE OR NAME J. P. Courson ADDRESS Farina, Illinois			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MASSIVE PLEURAL EFFUSION ANTECEDENT CAUSES CARCINOMA OF RIGHT LUNG; PRIMARY DUE TO (b) SITE UNKNOWN DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS ARTERIO-SCLEROTIC HEART DISEASE WITH CONGESTIVE HEART FAILURE Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION NONE	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS 2--6 MONTHS. SEVERAL YR 24 HOURS.	
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 type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 1.63X	
22. I hereby certify that I attended the deceased from 12/24, 1952 , to 1/11, 1953 , that I last saw the deceased alive on 1/11, 1953 , and that death occurred at 5:00 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE J. P. Bradley (Degree or title) M.D.		23b. ADDRESS 600 S. KINGSHIGHWAY	
23c. DATE SIGNED 1-4-53		24a. LOCATION (City, town, or county) (State) Farina, Illinois	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-5-53	24c. NAME OF CEMETERY OR CREMATORY	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington	
(Licensed Embalmer's Statement on Reverse Side)			

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 John S. Bernick
Licensed Embalmer No. 4199
P. O. Address St. Louis

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.