

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43935**

FILED JAN 7 1954

BIRTH NO. REG. DIST. NO. **282** PRIMARY REG. DIST. NO. **5976** Registrar's No. **169**

0540

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

1. PLACE OF DEATH a. COUNTY Polk		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Polk	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Willard Rt. #1		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Willard Rt. #1	
c. LENGTH OF STAY (in this place) 20 yrs.		d. STREET ADDRESS (If rural, give location) 8 mi. North of Willard	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. FULL NAME OF HOSPITAL OR INSTITUTION	
3. NAME OF DECEASED (Type or Print) a. (First) Newton		b. (Middle) Carroll	
c. (Last) Howard		4. DATE OF DEATH (Month) (Day) (Year) Dec. 27 1953	
5. SEX M.	6. COLOR OR RACE Wh.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 30 1861
9. AGE (In years last birthday) 92	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (City and State or Foreign Country) Greene Co. Mo.	12. CITIZEN OF WHAT COUNTRY? USA.
13a. FATHER'S NAME Carroll Howard	13b. MOTHER'S MAIDEN NAME Nancy Turley	14. NAME OF HUSBAND OR WIFE Mary Elizabeth Howard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Noah E. Pressley	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral apoplexy ANTECEDENT CAUSES Generalized arteriosclerosis DUE TO (b) Generalized arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.	
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) 334X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		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 July 1953 , to Dec 27, 1953 , that I last saw the deceased alive on July 1953 , and that death occurred at Two P.M. , from the causes and on the date stated above.	
23a. SIGNATURE D. McLean		23b. ADDRESS Bolivar Mo	
23c. DATE SIGNED 12/28/53		24a. BURIAL, CREMATION, REMOVAL (Specify) burial	
24b. DATE		24c. NAME OF CEMETERY OR CREMATORY Brighton Cemetery	
24d. LOCATION (City, town, or county) (State) Brighton Mo		25. FUNERAL DIRECTOR'S SIGNATURE Willard B. Erwid	
25. DATE REC'D BY LOCAL REG. 12/30/53		25. ADDRESS Mo	

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

Obey Jester

Licensed Embalmer No. *4154*

P. O. Address *Bolivar, Md*

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.