

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14832

STATE FILE NUMBER

FILED MAY 6 - 1957

318

Primary Registration District No.

1003

Registrar's No.

3742

Registration District No.

Health,  
& Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ill. Nois</i> b. COUNTY <i>Jersey</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MO.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Jerseyville</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>BARNES HOSPITAL</i>		Length of stay in lb <i>18 days</i>	d. STREET ADDRESS <i>112 MARION ST</i> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>WILLIAM</i> Middle <i>RILEY</i> Last <i>HOWLAND</i>			4. DATE OF DEATH Month <i>APRIL</i> Day <i>18</i> Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT. 7 - 1876</i>
9. AGE (In years last birthday) <i>80</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARMER</i>	11. BIRTHPLACE (City and state or country) <i>HAMBURG ILL</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Wm J. Howland</i>	
14. MOTHER'S MAIDEN NAME <i>SURILDIA CRAIG MILES</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No.</i>	
16. SOCIAL SECURITY NO. <i>341-16-7379</i>		17. INFORMANT Address <i>Jerseyville</i> <i>Lena Howland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>LYMPHOCYTTIC LEUKEMIA</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 YRS.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>204.0</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <i>APRIL 1, 1957</i> to <i>APRIL 18, 1957</i> and last saw her alive on <i>APR. 18, 1957</i> Death occurred at <i>10:20 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. E. Vermillion, M.D.</i>		(Degree or title) <i>M. D.</i>	22b. ADDRESS <i>BARNES HOSPITAL</i>
22c. DATE SIGNED <i>4/19/57</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>4-19-57</i>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <i>Jerseyville Ill</i>
24. FUNERAL DIRECTOR <i>JACOBY BROS</i>	ADDRESS <i>Jerseyville, Ill</i>	25. DATE RECD. BY LOCAL REG. <i>APR 19 57</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith, MO</i>

(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 .....  
Signature of Student Embalmer

Signed *Frank Provey* .....  
Licensed Embalmer No. *435*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.