

S. No. 200
V. 10-48

FILED OCT 28 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38651**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **590** Registrar's No. **2425**

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St Louis CO	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Ann		c. CITY OR TOWN St Ann	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 5 yr.		e. STREET ADDRESS (If rural, give location) 4523 Ashby Rd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4523 Ashby Rd.			

3. NAME OF DECEASED (Type or Print) a. (First) ELMER b. (Middle) REAVTS c. (Last) HOWELL			4. DATE OF DEATH (Month) (Day) (Year) Sept, 30, 1957		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH June 17, 1922			9. AGE (In years) (Months) (Days) (Hours) (Min.) 35 3 13		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lead Press Operator for General Cables			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (City and State or Foreign Country) Troy MO.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME Elmer Howell		13b. MOTHER'S MAIDEN NAME Lillie Holmes		14. NAME OF HUSBAND OR WIFE Beatrice Darlene Howell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Beatrice Darlene Howell 4523 Ashby Rd. St Ann MO.	

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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute Coronary Thrombosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
---	--	--	--	----------------------------------	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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) (Min.)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **11:44 p m.**, from the causes and on the date stated above.

23a. SIGNATURE Herbert R. Donke MD (Degree or title) Local Registrar		23b. ADDRESS 651 S. Brentwood, Clayton, Mo.		23c. DATE SIGNED 10/14/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct. 3, 1957		24c. NAME OF CEMETERY OR CREMATORY Hawkpoint Cemetery	
				24d. LOCATION (City, town, or county) (State) Hawkpoint Mo.	

DATE REC'D BY LOCAL REG. 10-1-57		REGISTRAR'S SIGNATURE Herbert R. Donke MD		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS D.W. Mc Coy Troy mo.	
---	--	--	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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

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..... *D. W. McEary*

Licensed Embalmer No. *3586*

P. O. Address *Jay Ma*

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.