

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035675

STATE FILE NUMBER

FILED OCT 20 1958

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 228

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1-57

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1. PLACE OF DEATH a. COUNTY CALLAWAY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY RANDOLPH	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FULTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN MOBERLY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. HOSPITAL #1		Length of stay in 1b 23yr 4mo	d. STREET ADDRESS 0883 (If outside, give location)
3. NAME OF DECEASED (Type or print) First REBA Middle Last HOWELL		4. DATE OF DEATH October 10 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/1897
9. AGE (In years at birthday) 61		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during 1 year immediately preceding death, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) RANDOLPH COUNTY MO
10a. HOUSEWORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME R.R. McDONALD		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE MARTIN HOWELL
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address St. Hospital No. 1, Fulton, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Natural Cause			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. } DUE TO (b) _____ DUE TO (c) _____ 7954			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Schizophrenic Reaction			19. WAS AUTOPSY PERFORMED? 2 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 WORK 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. Continued the deceased from 6/1/1935 , to 10/10/1958 and last seen alive on the date stated above and to the best of my knowledge from the causes stated .			
22a. SIGNATURE Erwin Leonhardt, MD (Name and title)		22b. ADDRESS St. Hospital No. 1	22c. DATE SIGNED 10/10/58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Oct. 13 / 58	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) Columbia (State) MO
24. FUNERAL DIRECTOR Robert D. Johnston ADDRESS Columbia MO		25. DATE RECD. BY LOCAL REG. Oct 13-1958	26. REGISTRAR'S SIGNATURE Marretta Lawrence

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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

Licensed Embalmer No.....

P. O. Address.....

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.