

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036431

STATE FILE NUMBER

FILED NOV 7 1958

Registration District No. 149 Primary Registration District No. 1622 Registrar's No. 4865

S. 300  
v. 1-57

|   |                               |   |   |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>                  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>   |                               | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>  |                               | Length of stay in lb<br><b>35 years</b>   | d. STREET ADDRESS (If outside, give location)<br><b>5829 E. 9th St.</b>                           |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HOWARD</b> Middle <b>LEE</b> Last <b>HOWELL, SR.</b>  |                               |   | 4. DATE OF DEATH<br>Month <b>Oct.</b> Day <b>15</b> Year <b>1958</b>                              |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 25, 1910</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Crane Helper</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Sheffield Steel</b>   | 9. AGE (In years last birthday) <b>48</b>   |
| 11. BIRTHPLACE (City and state or country)<br><b>Garfield, Arkansas</b>   |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13a. FATHER'S NAME<br><b>Henry R. Howell</b>  |                               | 13b. MOTHER'S MAIDEN NAME<br><b>Cora Pratt</b>  | 14. NAME OF HUSBAND OR WIFE<br><b>Coline Howell</b>   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                               | 16. SOCIAL SECURITY NO.<br><b>702-14-5953</b>   | 17. INFORMANT Address<br><b>Mrs. Coline Howell, 5829 E. 9th St., K.C., Mo.</b>                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>  |                               |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Arterio Sclerotic Heart Disease</b>   |                               |   | 4 mo  |
| DUE TO (c) <b>Diabetes Mellitus</b>   |                               |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a))   |                               |   | 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ 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 <b>6-20-58</b> to <b>10-15-58</b> and last saw him alive on <b>Oct. 14-58</b><br>Death occurred at <b>3:20 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                               |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>Hubert M. Parker M.D.</b>  |                               | 22b. ADDRESS<br><b>928 Argyle Bldg</b>  | 22c. DATE SIGNED<br><b>10-15-58</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>10-18-58</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park Cemetery</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City, Missouri</b>                     |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Geo. C. Carson &amp; Sons, Indep., Mo.</b>   |                               | 25. DATE RECD. BY LOCAL REG.<br><b>10-15-58</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Neva Minshell</b>   |

All diseases in Part I must be causally related.  
 Every cause, etc., must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

Hubert M. Parker

WV 2-3233



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 *Dean W. Huff* .....

Licensed Embalmer No. *4914* .....

P. O. Address *Indgo, Mo* .....

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.