

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018486
STATE FILE NUMBER

FILED JUN 15 1959 Registration District No. 227 Primary Registration District No. 5804 Registrar's No. 18

S. 300
1-57 4

1. PLACE OF DEATH a. COUNTY <u>Monroe</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Monroe</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Middle Grove</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pleasant View Rest Home</u>		Length of stay in 1b <u>2 months</u>	d. STREET ADDRESS (If outside, give location) <u>S.W. Middle Grove</u>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>John Henry Howard</u>			4. DATE OF DEATH Month Day Year <u>June 5-1959</u>		
--	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17, 1870</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months Days - -	IF UNDER 24 HRS. Hours Min. - -
-----------------------	----------------------------------	---	--	--	---------------------------------------	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>	11. BIRTHPLACE (City and state or country) <u>Chariton Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	--	--	---

13a. FATHER'S NAME <u>John W. Howard</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE - - - -
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MRS. ALVA WEST, Paris, Mo.</u>
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4/201</u>	

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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
--	--	--

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 June 5-1959 to June 5-1959 and last saw him alive on June 5-1959
Death occurred at 4:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (D, free or title) <u>John W. Barnette M.D.</u>	22b. ADDRESS <u>Paris, Mo.</u>	22c. DATE SIGNED <u>6-6-59</u>
---	-----------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 7-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Keytesville Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Keytesville, Mo.</u>
--	---------------------------------	---	--

24. FUNERAL DIRECTOR <u>Thompson-Mackler, Madison, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-6-59</u>	26. REGISTRAR'S SIGNATURE <u>J. A. Barnette M.D.</u>
---	---	---

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

550

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 *Joseph R. Mackler*

Licensed Embalmer No. *4571*

P. O. Address *Madison, W*

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.