

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021965

STATE FILE NUMBER

FILED JUN 26 1959

Registration District No. 160 Primary Registration District No. 559 Registrar's No. 9a

300
-57

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joachim Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Barnhart</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jeff. Memorial Hosp</u>		Length of stay in 1b <u>1 hour</u>	d. STREET ADDRESS (If outside, give location) <u>150</u> RESIDE ON FARM Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Neta</u> Middle <u>Fay</u> Last <u>Howell</u>			4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1959</u>
9. AGE (In years last birthday) <u>0</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Festus, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Robert Howell</u>	
13b. MOTHER'S MAIDEN NAME <u>Juanita Coffman</u>		14. NAME OF HUSBAND OR WIFE <u>Never Married</u>	
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>Robert Howell, Barnhart, 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>Marked prematurity incompatible with life</u> DUE TO (b) <u>Abruptio placentae</u> 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>7615</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs.</u> <u>6 hrs.</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 _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <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 <u>June 16, 1959</u> , to <u>June 16, 1959</u> and last saw her alive on <u>June 16, 1959</u> Death occurred at <u>4:45 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>F. L. Kuzal, M.D.</u>		22b. ADDRESS <u>Crystal City, Mo.</u>	22c. DATE SIGNED <u>6-18-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 17, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>
23d. LOCATION (City, town, or county) <u>Festus, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Vinyard Fun'l Homes, Inc., Festus, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-20-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

DATE JUN 24 1959

STATEMENT BY LICENSED EMBALMER

NOT
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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 W. B. King

Licensed Embalmer No. 4976
P. O. Address Festus

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.