

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028394

LED VS. SEP 8 1959 53

Registration District No. \_\_\_\_\_ Primary Registration District No. 3010

Registrar's No. 308

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cape Girardeau</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u> Length of stay in 1b <u>2 wk</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u> c. CITY OR TOWN <u>Advance</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Cypress St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <u>Hyka</u> Middle <u>Brown</u> Last <u>Howell</u>			<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>29</u> Year <u>1959</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>JAN. 4, 1889</u>	<b>9. AGE (last birthday)</b> <u>70</u>	<b>IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>25</u> Hours <u>   </u> Min. <u>   </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Household</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Bycannon, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>Calvin Brown</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>JENNIE N. Arnold</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Adrian C. Howell</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> Address <u>Adrian C. Howell, Advance, Mo.</u>			

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction - arteriosclerotic heart disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH ? ?
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus. Urinary tract infection.</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____				

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b> <b>STATE</b>
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21. I attended the deceased from 8-18-59 to 8-29-59 and last saw her alive on 8-29-59  
 Death occurred at 8-29-59 at 11.45 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Charles F. Wilson M.D.</u>	<b>22b. ADDRESS</b> <u>714 Broadway, Cape Girardeau, Mo.</u>	<b>22c. DATE SIGNED</b> <u>Mo. 9-1-59</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>9-2-59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Maryann Mem. Park</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Advance, Mo.</u>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>W. H. Morgan, Advance, Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-2-1959</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Drew Kartin</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W<sup>m</sup> A. Morgan

Licensed Embalmer No. 4640

P. O. Address Advance,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.