

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

59-029601

STATE FILE NUMBER

Registration District No. 767 Primary Registration District No. 4256 Registrar's No. 34

DED

1. PLACE OF DEATH a. COUNTY <u>JOHNSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>JOHNSON</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HOLDEN</u>		Length of stay in 1b <u>15 YR</u>		c. CITY OR TOWN <u>HOLDEN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2ND &amp; PINE STS</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2ND &amp; PINE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER VAN HOWARD</u>				4. DATE OF DEATH Month Day Year <u>AUG 24 1959</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-5-1893</u>	9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MERCHANT</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOTEL &amp; GROCER</u>		11. BIRTHPLACE (City and state or country) <u>TONGANOXIE KANSAS</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13a. FATHER'S NAME <u>WILLIAM HOWARD</u>			13b. MOTHER'S MAIDEN NAME <u>BLANCHÉ (UNKNOWN)</u>		14. NAME OF HUSBAND OR WIFE <u>BERTHA DAVIDSON HOWARD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>159-18-2207</u>		17. INFORMANT Address <u>BERTHA HOWARD HOLDEN, 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>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Disease</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>Duodenal Ulcer</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			
19. WAS AUTOPSY PERFORMED? 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 a.m. p.m. Month, Day, Year								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>Aug 5 1959</u> to <u>Aug 24 1959</u> and last saw him alive on <u>Aug 24 1959</u> Death occurred at <u>7:05 pm</u> m on the date stated above, and to the best of my knowledge from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Kelly Rawlins M.D.</u>			22b. ADDRESS <u>Holden, Missouri</u>			22c. DATE SIGNED <u>7/26/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-26-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HUBBLE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>TONGANOXIE KANSAS</u>				
24. FUNERAL DIRECTOR <u>CANADAY &amp; ROPP</u>		ADDRESS <u>HOLDEN MO</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 26, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. G. V. Redford</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

193 NOV 9 1934

**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 *M. J. Quaday*

Licensed Embalmer No. 343

P. O. Address Helden

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