URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS MAR 8 1960

60-005671

STATE FILE NUMBER

Registration District No. 93 Primary Registration District No. _____ Registrar's No. 60-15

ENDED

1. PLACE OF DEATH
a. COUNTY: Dade
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: South Greenfield
Length of stay in 1b: 55 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 2 mi. S.E. of So. Greenfield
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Dade
c. CITY OR TOWN: South Greenfield
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 2 mi. S.E. of So. Greenfield
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First WILLIAM Middle CHALMERS Last HOWELL

4. DATE OF DEATH: Month FEB Day 18 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8-4-80
9. AGE (last birthday): 79
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HR: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (City and state or country): 6 mi. N.W. of Greenfield, Mo
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Willis Elmer Howell
13b. MOTHER'S MAIDEN NAME: Mary Margret Jordan
14. NAME OF HUSBAND OR WIFE: Jeannette Howell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 497-40-8276
17. INFORMANT: Bertha Russell
Address: Ash Grove, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac decompensation c. auricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular disease — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Jan 1958 to Feb 18, 60 and last saw her/him alive on Feb 18, 1960
Death occurred at 7:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: A. R. Cain M.D. (Degree or title)
22b. ADDRESS: Lamar, Mo
22c. DATE SIGNED: 2/28/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-24-60
23c. NAME OF CEMETERY OR CREMATORY: Pennsboro Cemetery
23d. LOCATION (City, town, or county) (State): Pennsboro Missouri

24. FUNERAL DIRECTOR: Brum - Daniel
ADDRESS: Ash Grove Mo
25. DATE RECD. BY LOCAL REG.: Mar. 1, 1960
26. REGISTRAR'S SIGNATURE: J. C. Canada

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER MAY 19 1960

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_____ Signed Doyle L. Samuel

Signature of Student Embalmer

Licensed Embalmer No. 4202

P. O. Address Ash Gro

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