

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 29 1960

60-014272

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 481 STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> | | Length of stay in 1b <u>35 years</u> | c. CITY OR TOWN <u>St. Joseph</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>Mo. Methodist Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>119 Tucker St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>LEMUEL</u> Last <u>HOWELL</u> | | | 4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1960</u> | | |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</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>9/16/1895</u> | 9. AGE (last birthday) <u>64</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Goetz Brewery</u> | 11. BIRTHPLACE (City and state or country) <u>Faucett, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Lemuel W. Howell</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary E. Roney</u> | 14. NAME OF HUSBAND OR WIFE <u>Lillian Howell</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes W.W.I</u> | 16. SOCIAL SECURITY NO. <u>491-10-1976</u> | 17. INFORMANT <u>Lillian Howell-119 Tucker St.</u> | Address |
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| 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>Neoplasm of Brain (? Metastatic)</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) _____ | |
| | DUE TO (c) _____ | |

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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) | 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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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ | Month, Day, Year |
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| 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 11 April '60 to 17 April '60 and last saw her/him alive on April 17, 1960
Death occurred at 4:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>William G. Lockhart M.D.</u> (Degree or title) | 22b. ADDRESS <u>902 Edmond St. - St. Joseph, Mo</u> | 22c. DATE SIGNED <u>4/18/60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>April 19, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo</u> |
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| 24. FUNERAL DIRECTOR <u>Edward Clark</u> ADDRESS <u>St. Joseph, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>April 25, 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u> |
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DOCUMENT

BY AFFIDAVIT OF Wm G. Lockhart, M.D. MEDICAL CERTIFICATION

JUN 1
1960

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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 Emma Clark

Licensed Embalmer No. 4230

P. O. Address St. Louis

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.