URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 15 1960

-60-026499

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 844

NDED

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1623 Irving — Inside Limits Yes # No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Springfield — Inside Limits Yes # No ☐
d. STREET ADDRESS (If outside, give location) 1335 N. Broadway — Reside on Farm Yes ☐ No #

3. NAME OF DECEASED (Type or print) First Charles Middle Leslie Last Howell

4. DATE OF DEATH Month August Day 6 Year 1960

5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Widowed # Never Married ☐ Divorced ☐
8. DATE OF BIRTH 3-25-1878
9. AGE (last birthday) 82 — 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) Painter & Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Building
11. BIRTHPLACE (City and state or country) Vera, Illinois
12. CITIZEN OF WHAT COUNTRY U S A

13a. FATHER'S NAME Thomas Howell
13b. MOTHER'S MAIDEN NAME Dorothy Hall
14. NAME OF HUSBAND OR WIFE Dorothy Howell, deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 495-16-4517
17. INFORMANT Address Mr. Adrian C. Howell, Advance, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH 3 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Vascular disease — unknown
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 Springfield COUNTY Greene STATE Mo

21. I attended the deceased from Oct 28, '59, to Aug 6 '60 and last saw her/him alive on Oct. 5, '59
Death occurred at 12:30 p. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] M.D.
22b. ADDRESS 609 Cherry St.
22c. DATE SIGNED 8 Aug 60

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 8-6-1960
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) Advance (State) Missouri

24. FUNERAL DIRECTOR ADDRESS Rex Rainey, Springfield, Mo.
25. DATE RECD. BY LOCAL REG. 8-12-60
26. REGISTRAR'S SIGNATURE Effie B. Meeton

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

AUG 16 1960

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 456

P. O. Address_____

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