

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-042535**

FILED VS NOV 22 1960

Registration District No. 157 Primary Registration District No. 5589 Registrar's No. 226

STATE FILE NUMBER

|                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                                          |                                                                                                                                      |                                                                                                                                                                      |                                                                                      |                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jasper</u>                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                             |                                                                                          | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Jasper</u> |                                                                                                                                                                      |                                                                                      |                                                                                       |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>UNION Route 3, Carthage</u>                                                                                                                                                                                                                                                |                                                                                                           | Length of stay in lb <u>51 yrs</u>                                                                                                                          |                                                                                          | c. CITY OR TOWN <u>Carthage</u>                                                                                                      |                                                                                                                                                                      | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                                                                                       |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Route 3, Carthage</u>                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>     | d. STREET ADDRESS (If outside, give location) <u>Route 3</u>                                                                         |                                                                                                                                                                      |                                                                                      | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Hattie Lorena</u> Middle <u>Howard</u> Last <u>Howard</u>                                                                                                                                                                                                                                       |                                                                                                           |                                                                                                                                                             |                                                                                          | 4. DATE OF DEATH<br>Month <u>Nov.</u> Day <u>8,</u> Year <u>1960</u>                                                                 |                                                                                                                                                                      |                                                                                      |                                                                                       |
| 5. SEX<br><u>female</u>                                                                                                                                                                                                                                                                                                                         | 6. COLOR OR RACE<br><u>white</u>                                                                          | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |                                                                                          | 8. DATE OF BIRTH<br><u>May 11-1892</u>                                                                                               | 9. AGE (last birthday)<br><u>68</u>                                                                                                                                  | IF UNDER 1 YEAR<br>Months <u>        </u> Days <u>        </u>                       | IF UNDER 24 HR<br>Hours <u>        </u> Min. <u>        </u>                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>                                                                                                                                                                                                                                 |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>none</u>                                                                                                            |                                                                                          | 11. BIRTHPLACE (City and state or country)<br><u>Sarcoxie, Rte. 1, Mo.</u>                                                           |                                                                                                                                                                      | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>                                            |                                                                                       |
| 13a. FATHER'S NAME<br><u>Phillip Berger</u>                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             | 13b. MOTHER'S MAIDEN NAME<br><u>Minnie West</u>                                          |                                                                                                                                      | 14. NAME OF HUSBAND OR WIFE<br><u>Frank Howard</u>                                                                                                                   |                                                                                      |                                                                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>                                                                                                                                                                                                                           |                                                                                                           | 16. SOCIAL SECURITY NO.<br><u>none</u>                                                                                                                      |                                                                                          | 17. INFORMANT<br>Address<br><u>Frank Howard, Rte. 3, Carthage, MO.</u>                                                               |                                                                                                                                                                      |                                                                                      |                                                                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal Pulmonary Edema.</u><br>DUE TO (b) <u>Atherosclerotic Heart Disease</u><br>DUE TO (c) <u>        </u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                                                                                           |                                                                                                                                                             |                                                                                          |                                                                                                                                      |                                                                                                                                                                      | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>Coronary Sclerosis</u>       |                                                                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Stand. Hal.</u>                                                                                                                                                                                         |                                                                                                           |                                                                                                                                                             |                                                                                          |                                                                                                                                      | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                                                                                      |                                                                                       |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <u>        </u> Month, Day, Year <u>        </u><br>a.m. <u>        </u> p.m. <u>        </u>                                                                                                                                                                                                                       |                                                                                                           | 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>9-29-60</u> to <u>11-4-60</u> and last saw her alive on <u>11-4-60</u><br>Death occurred at <u>11:00 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.                                                                                                               |                                                                                                           |                                                                                                                                                             |                                                                                          |                                                                                                                                      |                                                                                                                                                                      |                                                                                      |                                                                                       |
| 22a. SIGNATURE (Degree or title)<br><u>Wm. Wells-Dee. D.O.</u>                                                                                                                                                                                                                                                                                  |                                                                                                           |                                                                                                                                                             |                                                                                          | 22b. ADDRESS<br><u>914. W. Sangley, Webb City Mo</u>                                                                                 |                                                                                                                                                                      | 22c. DATE SIGNED<br><u>11/12/60</u>                                                  |                                                                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>burial</u>                                                                                                                                                                                                                                                                                      | 23b. DATE<br><u>Nov. 11, 1960</u>                                                                         | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Center Cemetery</u>                                                                                                |                                                                                          | 23d. LOCATION (City, town, or county)<br><u>Jasper Mo.</u>                                                                           |                                                                                                                                                                      | (State)                                                                              |                                                                                       |
| 24. FUNERAL DIRECTOR<br><u>The Ulmer Funeral Home, Carthage, Mo.</u>                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                             | 25. DATE RECD. BY LOCAL REG.<br><u>11-16-60</u>                                          |                                                                                                                                      | 26. REGISTRAR'S SIGNATURE<br><u>WJ Chutkan</u>                                                                                                                       |                                                                                      |                                                                                       |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 24 1961

**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 *Johnnie L. Shuck*

Licensed Embalmer No. 495

P. O. Address *Partway*

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.