

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031829

STATE FILE NUMBER

Registration District No. 30 Primary Registration District No. 5103 Registrar's No. 31

AMENDED

FILED SEP 18 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Benton</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lindsey Township</u>	a. STATE <u>Mo.</u>	b. COUNTY <u>Benton</u>
c. FULL NAME OF (If NOT in hospital give location) HOSPITAL OR INSTITUTION <u>— Edwards</u>		c. CITY OR TOWN <u>Climax Springs</u>	d. STREET ADDRESS (If outside give location) <u>—</u>
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First <u>James Sylvester Howard</u>	Middle <u>—</u>	Last <u>Howard</u>	4. DATE OF DEATH	Month <u>Sept.</u>	Day <u>3</u>	Year <u>1961</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>2/2/1884</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>—</u>	IF UNDER 24 HR Days <u>—</u>	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>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Climax Springs Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Asa Howard</u>	13b. MOTHER'S MAIDEN NAME <u>Sarab E. Smith</u>	14. NAME OF HUSBAND OR WIFE <u>Maud Howard</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>No</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Mrs. E. S. Kirksirk Cole Camp Mo</u>	Address <u>—</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY:	IMMEDIATE CAUSE (a) <u>MEDULLARY PARALYSIS</u>	INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CEREBRAL HEMORRHAGE</u>	<u>30 MIN.</u>
	DUE TO (c) <u>ARTERIOSCLEROSIS</u>	<u>10 YRS.</u>

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 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.)
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20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m.	Month, Day, Year <u>—</u>
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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 <u>—</u>	COUNTY <u>—</u>	STATE <u>—</u>
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21. I attended the deceased from JAN., 15, 1955 to SEPT., 3, 1961 and last saw her live on SEPT., 4, 1961
Death occurred at 1:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Sussalloy DO</u>	(Degree or title)	22b. ADDRESS <u>WARSAW, MO.</u>	22c. DATE SIGNED <u>9-5-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 6, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cole Camp Cemetery</u>	23d. LOCATION (City, town, or county) <u>Cole Camp Mo.</u>	(State)
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24. FUNERAL DIRECTOR <u>F. L. Eickhoff</u>	ADDRESS <u>Cole Camp Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 11-1961</u>	26. REGISTRAR'S SIGNATURE <u>Jas. A. Logan</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS OR THIS RECORD ARE AS FOLLOWS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

E. L. Eickhoff

Licensed Embalmer No.

730

P. O. Address

Cole Camp

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.