

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033375

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 559v Registrar's No. 15v

AMENDED

FILED SEP 27 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>JEFFERSON</u>	a. STATE <u>MO</u>		b. COUNTY <u>JEFFERSON</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>JOABHIM TOWNSHIP</u>	Length of stay in 1b <u>5 MONTHS</u>	c. CITY OR TOWN <u>ARNOLD</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>MOUNTAIN VIEW</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>ARNOLD TUNNEL ROUTE</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
HOSPITAL OR INSTITUTION <u>CONVALESCENT HOME</u>			

3. NAME OF DECEASED (Type or print)	First <u>FANNIE</u>	Middle <u>HOWELL</u>	Last	4. DATE OF DEATH	Month <u>SEPT</u>	Day <u>18</u>	Year <u>1961</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 5, 1875</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>JEFFERSON MO COUNTY</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
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13a. FATHER'S NAME <u>HENRY NEVELS</u>	13b. MOTHER'S MAIDEN NAME <u>UNAVOIDABLE</u>	14. NAME OF HUSBAND OR WIFE <u>CHARLES HOWELL (DEC)</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>NONE</u>	17. INFORMANT <u>SAM THEREAU ARNOLD MO</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:	INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo +</u>
IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b)	
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. <input type="checkbox"/> Yes <input checked="" 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 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 <u>Crystal City, Mo.</u>	COUNTY	STATE
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21. I attended the deceased from <u>3-20-61</u> to <u>9-18-61</u> and last saw her/him alive on <u>9-18-61</u> Death occurred at <u>3:15 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>R.D. Howell, M.D.</u> (Degree or title)	22b. ADDRESS <u>112 Mississippi Ave. Crystal City, Mo.</u>	22c. DATE SIGNED <u>9-19-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT 20 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HERCULANEUM</u>	23d. LOCATION (City, town, or county) <u>HERCULANEUM MO</u>
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24. FUNERAL DIRECTOR <u>HELLICATAG FUNERAL HOME IMPERIAL MO</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>9-19-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

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 Elmer A. Halitag

Licensed Embalmer No. 3571

P. O. Address Imperial MD

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.