

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035751

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1308 STATE FILE NUMBER

FILED OCT 9 1963

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arkansas</u> b. COUNTY <u>Lawrence</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b		c. CITY OR TOWN <u>Hoxie</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Johns Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lenoir</u> Middle <u>Charles</u> Last <u>Howell</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/16</u>	9. AGE (last birthday) <u>46</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>25</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ranch Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ranching</u>		11. BIRTHPLACE (City and state or country) <u>Imboden, Arkansas</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>L. C. Howell</u>		13b. MOTHER'S MAIDEN NAME <u>Susan E. Moore</u>	
14. NAME OF HUSBAND OR WIFE <u>Never Married</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>No</u>		16. SOCIAL SECURITY NO. <u>73</u>	
17. INFORMANT <u>Mrs. A. V. Dixon</u>		Address <u>Springfield, Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Carcinoma, rt. lung</u> DUE TO (c) <u></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	
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.)	
20c. TIME OF INJURY Hour <u></u> s.m. <u></u> p.m. <u></u>		Month, Day, Year <u></u>		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 <u>20 Dec. 1962</u> to <u>26 Sept. 1963</u> and last saw her alive on <u>26 Sept. 1963</u> . Death occurred at <u>9:45 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Emmett E. Trabb, M.D.</u> (Degree or title)		22b. ADDRESS <u>16307 Jefferson</u>		22c. DATE SIGNED <u>5 Oct 63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/28/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kelly Cemetery</u>	
23d. FUNERAL DIRECTOR <u>Bryan Funeral Home</u>		ADDRESS <u>Hoxie, Ark.</u>		25. DATE RECD. BY LOCAL REG. <u>10-8-63</u>	
26. REGISTRAR'S SIGNATURE <u>Bernie Welby</u>		26. REGISTRAR'S SIGNATURE <u>Acting</u>			

USE BLACK INK OR TYPEWRITER RIBBON

7880  
08-08

9/26/63

**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 Robert F. Warden

Licensed Embalmer No. 1110

P. O. Address 160 Hope Ave.

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.