

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037669

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9271

STATE FILE NUMBER

**FILED SEP 19 1963**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>		c. CITY OR TOWN <b>Affton</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bethesda General Hospital</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>8117 Hildesheim</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JESS</b> Middle <b>E.</b> Last <b>HOWELL</b>			4. DATE OF DEATH Month <b>Sep.</b> Day <b>14</b> Year <b>1963</b>			5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>				
8. DATE OF BIRTH <b>10-10-1890</b>		9. AGE (last birthday) <b>72</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor (Retired) U. S. Post Office</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>				
11. BIRTHPLACE (City and state or country) <b>Farmington, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>William Howell</b>			13b. MOTHER'S MAIDEN NAME <b>LaFavor Ashburg</b>			14. NAME OF HUSBAND OR WIFE <b>Lester Howell</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Lester Howell 8117 Hildesheim</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Embolus of Right Pulmonary artery</b> DUE TO (b) _____ DUE TO (c) <b>Carcinoma of Colon 153.8</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Colon resection 8-21-63</b> 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			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>3 months</b>		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.		Month, Day, Year		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 <b>7-29-1963</b> to <b>9-14 1963</b> and last saw him alive on <b>9-14-1963</b> Death occurred at <b>5:00 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.														
22a. SIGNATURE (Degree or title) <b>John W. Stewart M.D.</b>						22b. ADDRESS <b>4660 Maryland Shores Mo</b>			22c. DATE SIGNED <b>9-16-63</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sep. 17, 1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cemetery</b>				23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>						
24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>SEP 16 1963</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>								

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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 James Robinson

Licensed Embalmer No. 4527

P. O. Address \_\_\_\_\_

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.