

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

33185

State File No.

Registrar's No. 1076

FILED OCT 24 1945

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution State Hosp # 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 mo 20 days  
(Specify whether years, months or days)  
In this community same

3. (a) PRINT FULL NAME Theodore Howard

3. (b) If veteran, name war - 3. (c) Social Security No. -

4. Sex M 5. Color or race N 6. (a) Single, widowed, married, divorced 7  
6. (b) Name of husband or wife Mary Howard 6. (c) Age of husband or wife if alive 73 years  
7. Birth date of deceased Jan 1874  
(Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 26 If less than one day hr. min.

9. Birthplace Emterville Ark  
(City, town, or county) (State or foreign country)

10. Usual occupation Stone Mason

11. Industry or business

12. Name Jefferson Howard  
13. Birthplace Emterville Ark  
(City, town, or county) (State or foreign country)  
14. Maiden name Martha Brinkman  
15. Birthplace Emterville Ark  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Howard  
(b) Address 318 Highland St. St. Joseph MO  
17. (a) Burial (b) Date thereof 10-6-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation State Hosp # 2

18. (a) Signature of funeral director Freeman & Son  
(b) Address St. Joseph, Mo  
19. (a) 10-9-1945 (b) L. J. Smith  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 318 Highland  
(If rural, give location)  
(e) Citizen of foreign country? - (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 5 year 1945 hour 7:15 minute 0 M.  
21. I hereby certify that I attended the deceased from Sept 27, 1945, to Oct 5, 1945, that I last saw him alive on Oct 4, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia  
Due to Cardiac decompensation  
Duration 3 days

Due to -  
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 107  
Of autopsy -  
PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify site of place)  
While at work? L. J. Smith (e) Means of injury -  
23. Signature L. J. Smith (M. D. or other)  
Address State Hosp # 2 St. Joseph Date signed 10/6/45

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 not  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed.....

Licensed Embalmer No. ....

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 this body is not embalmed, fact should be so stated above.**