Indiana State Board of Health
CERTIFICATE OF DEATH

¹PLACE OF DEATH

County of **Monroe**

Township of **Bloomington**

Registered No. **24271**

Town of _____

or

City of **Bloomington** (No. **414 W. 6th St.** St., _____ Ward)

[If death occurred in a Hospital or Institution, give its NAME instead of street and number.]

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information"]

²FULL NAME **Jesse A. Howe**

PERSONAL AND STATISTICAL PARTICULARS		
³SEX **Male**	⁴Color or Race **White**	⁵Single Married Widowed or Divorced (Write the word) **Married**

⁵ᵃ NAME OF HUSBAND OR WIFE (of deceased)

⁶DATE OF BIRTH (of deceased) **March** (Month) **11** (Date) **1869** (Year)

⁷AGE **58** years **5** months **14** days | If LESS than 1 day, ...hrs., or ....min.?

⁸OCCUPATION
(a) Trade, profession, or particular kind of work **Merchant**
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹BIRTHPLACE OF DECEASED (State or country) **Indiana**

¹⁰NAME OF FATHER **Joshua Howe**

¹¹BIRTHPLACE OF FATHER (State or country) **Indiana**

¹²MAIDEN NAME OF MOTHER **Margaet Able**

¹³BIRTHPLACE OF MOTHER (State or country) **Indiana**

PARENTS

¹⁴THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs Jesse Howe**

(Address) **414 W. 6th St.**

¹⁵Filed **Sept 2 27**

J E Moser M.D.
Name and Address of Health Officer or Deputy

MEDICAL CERTIFICATE OF DEATH

¹⁶DATE OF DEATH **Aug** (Month) **26** (Day) **19 27** (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from **aug 25 1927** to **aug 25 1927**

that I last saw h.... alive on **aug 25 19 27**

and that death occurred, on the date stated above, at **11** **50** P.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) **19** yrs. .... mos. .... ds.

Contributory (Secondary) **Arterio sclerosis**

(Duration) .... mos. .... ds.

(Signed) **Fred H Batman** , M.D.

aug 30, 19 27 (Address) **Bloomington**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

¹⁸LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or Usual Residence

¹⁹PLACE OF BURIAL OR REMOVAL **Bloomington Ind.**

DATE OF BURIAL **Aug. 29** 19 **27**

²⁰UNDERTAKER **W. W. Allen**

WAS THE BODY EMBALMED? **Yes**

²¹ADDRESS **Bloomington Ind.**

EMBALMER'S LICENSE No. **2346**