WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Adair

Township Benton or Village or City Kirksville (NO. ..... St.; ..... Ward)

Registration District No. 4 — File No. 26977

Primary Registration District No. 3001 — Registered No. 585

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Dr Robert M Fowler

PERSONAL AND STATISTICAL PARTICULARS

SEX: M — COLOR OR RACE: W — SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married widower 2 days

DATE OF BIRTH: June (Month) 9 (Day), 1850 (Year) a.w.p.

AGE: 76 yrs. 7 mos. 12 ds. — If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Physician 1858

(b) General nature of industry, business, or establishment in which employed (or employer): 1884

BIRTHPLACE (City or town, State or foreign country): Kentucky

PARENTS

NAME OF FATHER: John Fowler

BIRTHPLACE OF FATHER (City or town, State or foreign country): unknown

MAIDEN NAME OF MOTHER: unknown

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J W Fowler

(ADDRESS) Kirksville Mo

Filed 8 22 1916 A W Parnell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug (Month) 21 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from July 12, 1916, to Aug 21, 1916, that I last saw him alive on Aug 21, 1916, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows: Hepatitis 115

Several weeks (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) old age (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E D Quinn M. D.

Aug 22 1916 (Address) Kirksville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH 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

PLACE OF BURIAL OR REMOVAL: Forest Cem — DATE OF BURIAL: 8/22 1916

UNDERTAKER: Swigert & Rindon — ADDRESS: Kirksville

Revised United States Standard
Certificate of Death

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTI
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... , ... St.; ..... Ward) [If deat hospital give its of street

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) (Da

I HEREBY CERTIFY, that I attended dec

....., 191...., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stated above, a

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mo

Contributory .....
(SECONDARY)

..... (Duration) ..... yrs. ..... mo

(Signed) .....

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violen (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, T RECENT RESIDENTS)

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

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

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BU
UNDERTAKER	ADDRESS