JAN 28 1929

42193 - 42

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

1. PLACE OF DEATH
County: Ray
Township: Orrick
City: (No. ..... St. ..... Ward)
Registration District No.: 744
Primary Registration District No.: 597613
File No.:
Registered No.: 107

2. FULL NAME: Asa D Rowland

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Abbie Rowland

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 7 1860

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	68	5	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farming
(c) Name of employer: self

9. BIRTHPLACE (CITY OR TOWN): Orrick, Mo.
(STATE OR COUNTRY): Ray County

PARENTS
10. NAME OF FATHER: Asa Dolan Rowland
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Virginia
12. MAIDEN NAME OF MOTHER: Mary Lyman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Virginia

14. INFORMANT: F. S. Rowland
(Address): Richmond, Mo

15. FILED: Dec 24, 1928 R L Hamilton, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 16, 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1928, to Dec 16, 1928, that I last saw him alive on Dec 16, 1928, and that death occurred, on the date stated above, at 7:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arteriosclerosis, some Brain lesion, complication of diseases.
(duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Probably Apoplexy
(duration) ..... yrs. 2 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? No. DATE OF ✓
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) G. A. Lang, M. D.
Dec 20, 1928 (Address) Rayville, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Rowland Cemetery
DATE OF BURIAL: 12-18 1928

20. UNDERTAKER: F. S. Rowland
ADDRESS: Ra[illegible]

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.

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

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CERTIFICATE OF DEATH

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County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....

(Usual place of abode) (If nonresident give city or to

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....

(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....

(STATE OR COUNTRY)

14.

INFORMANT .....

(Address)

15.

FILED....., 19..... .....

REGISTRAR

MEDICAL CERTIFICATE OF DEAT

16. DATE OF DEATH (MONTH, DAY AND YEAR)

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I HEREBY CERTIFY, That I attended dece

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

death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF...

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths fro (1) MEANS AND NATURE OF INJURY, and (2) whether HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

20. UNDERTAKER