

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

Do not use this space.

18546

PLACE OF DEATH

County Jasper
Township _____
City Webb City (No. _____)

Registration District No. 417
Primary Registration District No. 3021

File No. _____
Registered No. 60
St. _____ Ward _____

2. FULL NAME Frank Henry Cowen
(a) Residence No. 526 So. Madison 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 Mrs. Rebecca Cowen
6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 6, 1870
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
59 1 25

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Postman
(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) Limestone New York

10. NAME OF FATHER Isaac Henry Cowen
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Webb City New York
12. MAIDEN NAME OF MOTHER Anna L. Joseph
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Brookfield Penn.

14. INFORMANT Mr. Thomas W. Cowen
(Address) Webb City, Mo.

15. FILED 5/3 1929 R. M. Stormont
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/1 1929
17. I HEREBY CERTIFY, That I attended deceased from March 7, 1929, to May 1, 1929, that I last saw him alive on May 1, 1929, and that death occurred, on the date stated above, at 5:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
82A

CONTRIBUTOR (SECONDARY) 7401
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

18 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
18 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) J. R. Kitchett, M. D.
5/2, 1929 (Address) Webb City 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Hope
DATE OF BURIAL May 3 1929

20. UNDERTAKER Steele Und. Co.
ADDRESS Webb City Mo.

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.

JUN 28 1929

189
2
2
2
2

