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

Do not use this space.

7910

File No. .....

Registered No. 54

1. PLACE OF DEATH
County: Callaway
Registration District No. 104
Township: .....
Primary Registration District No. 3008
City: Fulton (No. State Hosp. St. ..... Ward)

2. FULL NAME: H. H. Rowland

(a) Residence. No. Boone Co Mo. 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. 22 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): No information

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	52			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer 75B
(b) General nature of industry, business, or establishment in which employed (or employer): 1240 131
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Boone Co
(STATE OR COUNTRY) America

PARENTS
10. NAME OF FATHER: Jack Rowland
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Boone Co Mo
12. MAIDEN NAME OF MOTHER: Fannie Shaw
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Boone Co Mo

14. INFORMANT: State Hospital Records
(Address) Fulton Mo.

15. FILED Mar. 5, 1930 R. N. Crews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): Mch. 5 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Feby. 12, 1930, to Mch. 4, 1930, that I last saw him alive on Mch. 4, 1930, and that death occurred, on the date stated above, at 2:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
a complication of diseases produced by alcohol (Cardio-renal-hepatic) Hypertrophic cirrhosis of liver; chronic parenchymatous nephritis; myocarditis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic alcoholism (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED N

IF NOT AT PLACE OF DEATH .....

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

8

(Signed) T. R. Frazer, M. D.
, 19 (Address) Fulton State Hospital

*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	DATE OF BURIAL
Harrisburg Mo	Mar 7 1930
20. UNDERTAKER	**ADDRESS**
T. O. M. McHARG	Columbia

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.