

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**

Do not use this space. *Cowden*

1. PLACE OF DEATH

County *Greene*
Township *Franklin*
City *Springfield* (No. *1*)

Registration District No. *322*
Primary Registration District No. *5446*

File No. *32674*
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence No. *1012 N. Robinson Ave* Springfield, Mo. 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 <i>Female</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Widow</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>March 19-1852</i>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>77</i>	<i>7</i>	<i>11</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *at home*

(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) *Mo.*

10. NAME OF FATHER *Allen Wallis*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *N. Car.*

12. MAIDEN NAME OF MOTHER *Miss E. Sedell*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *N. Car.*

14. INFORMANT *A. H. Wallis*
(Address) *Springfield Mo.*

15. FILED *Nov 19 30* *Miss Everett Tracy*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 30 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Oct 28*, 19*30* to *Oct 30*, 19*30* that I last saw *her* alive on *Oct 30*, 19*30* and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia

117
10977

(duration) yrs. mos. *2* ds.

CONTRIBUTORY (SECONDARY) *Influenza*
(duration) yrs. mos. *5* 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 *Clinical*

(Signed) *W. H. Cowden*, M. D.
Oct 31, 1930 (Address) *445 1/2 E. Commercial St*

*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 *Green Lawn Cemetery* DATE OF BURIAL *Nov 1 1930*

20. UNDERTAKER *J. W. Lingner & Co., Springfield, Mo.* ADDRESS *424 E. Commercial St*

39 NOV 22 1930 78-7-11

1000

1000

1000

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene
Township Franklin
City (No.)

Registration District No. 322
Primary Registration District No. 3446

File No.
Registered No.
St. Ward

2. FULL NAME

Malena Jane Cowden

(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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 19-1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 7 11

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)

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

128 1970 Mrs. Ewert Tracy
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 30 1970

17. I HEREBY CERTIFY That I attended deceased from 19.....
that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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)....., M. D.

, 19 (Address)

*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

20. UNDERTAKER

ADDRESS

19

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-32674