NOV 28 1930

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

Do not use this space.

35054

1. PLACE OF DEATH
County: Saline
Township: Salter
City: Salter (No. ..... St. ..... Ward)
Registration District No. .....
Primary Registration District No. 4479
File No. .....
Registered No. 63

2. FULL NAME Edward William Fowler

(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: Rosie Fowler

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 4 - 1858

7. AGE: Years 71 | Months 10 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): New York City
(STATE OR COUNTRY): New York

PARENTS
10. NAME OF FATHER: Washington
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Unknown
(STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Elizabeth Allen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): New York
(STATE OR COUNTRY): New York

14. INFORMANT: William Fowler
(Address): Slater Mo

15. FILED Oct 24 30, 19..... W M Tuttle
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 23 1930

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to Oct 23, 1930, that I last saw him alive on Sept 5, 1930, and that death occurred, on the date stated above, at 1 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Angina Pectoris
Gallstones
Cholecystitis (duration) 3 yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED: at Home
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) H B Lockwood, M. D.
Oct, 19 ..... (Address) Slater 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: Slater City Cemetery — DATE OF BURIAL: Oct 26 1930

20. UNDERTAKER: Jones and Stepp — ADDRESS: Slater Mo

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.