

OCT 24 1935

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

Do not use this space.

29840

1. PLACE OF DEATH

County

Township

City

Jackson
Madison
Carthage Mo

Registration District No.

Primary Registration District No.

4.68
5564

File No.

Registered No.

St.

Ward)

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

St.

Ward.

(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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Male

White

widowed

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

John Stowe

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

Dec 26 - 1898

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day,hrs. ormin.

56

6

6

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Green Co Mo

13. NAME

Isom L Chilcutt

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Tenn

15. MAIDEN NAME

Mathilde

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Mo

17. INFORMANT (ADDRESS)

Frank Stowe Carthage Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

Brookline Mo

Sept 4 1935

19. UNDERTAKER (ADDRESS)

Geo E Bradley Fairview Mo

20. FILED

19

Registrar.

MEDICAL CERTIFICATE OF DEATH

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

9/2

1935

22. I HEREBY CERTIFY, That I attended deceased from

July 1 1935, to July 1 1935

I last saw h. & A. alive on July 1 1935. Death is said

to have occurred on the date stated above, at 10:09 a.m.

The principal cause of death and related causes of importance were as follows:

Injury of lower neck

Made a diagnosis

Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

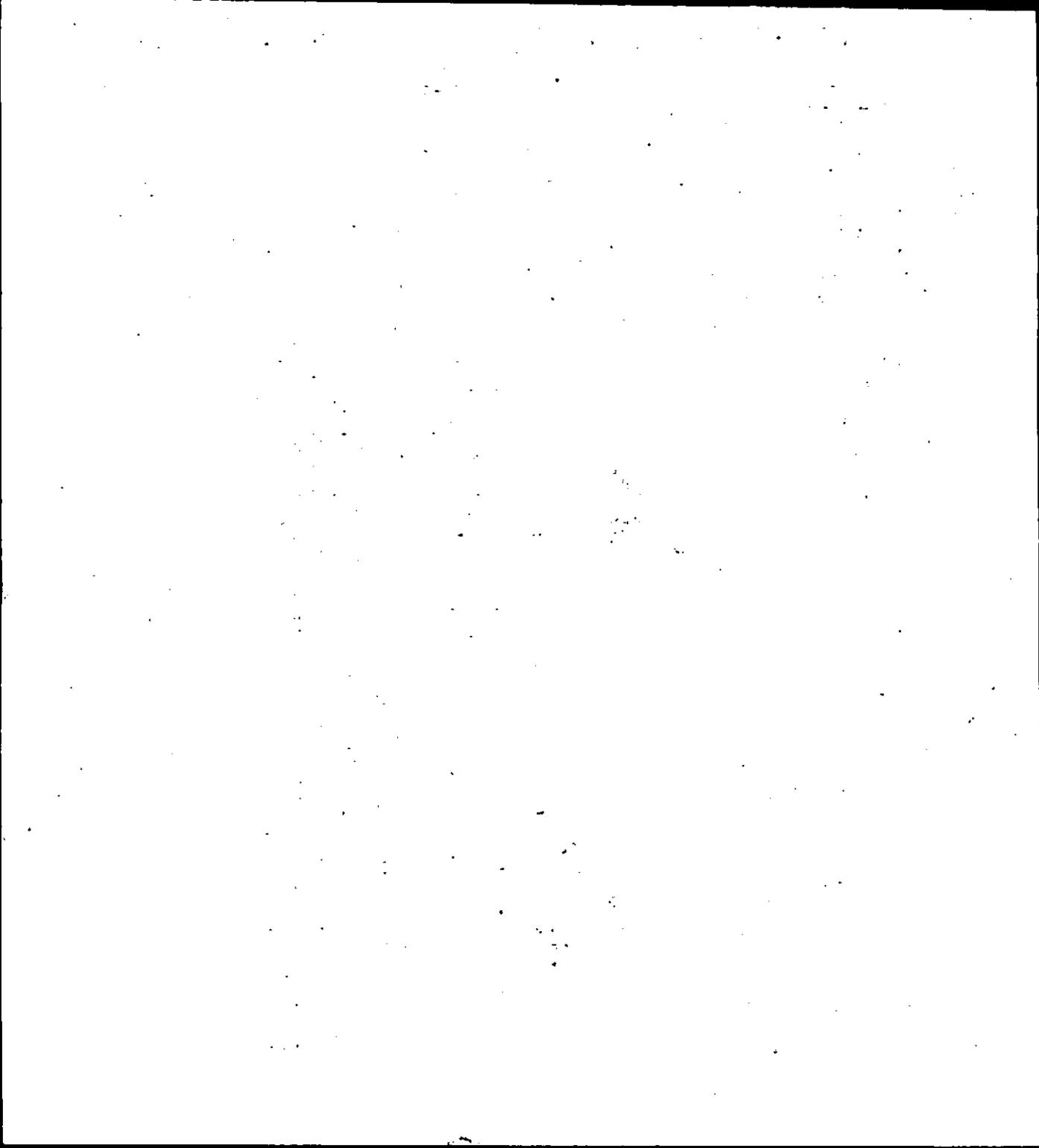
If so, specify

(Signed) W. E. Baker, M. D.

(Address)

Carthage 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.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
Do not use this space.
THIS SUPPLEMENTARY

1. PLACE OF DEATH

County Jackson
 Township Madison
 City _____ (No. _____ St. _____ Ward _____)

Registration District No. 408
 Primary Registration District No. 3564

File No. _____
 Registered No. _____

2. FULL NAME

Helene May Stowe

(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)

7. AGE YEARS 36 MONTHS 6 DAYS 1 (LESS than 1 day, _____ hrs. or _____ min.)

8. Trade, profession, or particular kind of work done, as spinner, Sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. UNDERTAKER (ADDRESS)

20. FILED Nov. 7 1935 E. B. Clinton Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/2 1935

I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

Last saw him _____ alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Cancer of face and neck Date of onset _____

Cancer face

Other contributory causes of importance:

No further information concerning primary site of metastases

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) X E Baker _____, M. D.

(Address) Carthage Mo.

EXHIBIT

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.

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