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.

OCT 21 1936

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

Do not use this space.

33944

1. PLACE OF DEATH

County Clay — Registration District No. 198 — File No.

Township ~~Fishing River~~ — Primary Registration District No. 3/11 — Registered No.

City Excelsior Springs, Mo. (No. , St. 3d Ward)

2. FULL NAME ROWLAND, Harry

(a) Residence, No. Veterans Administration Facility (Usual place of abode) Excelsior Springs, Mo. St., Ward. Rayville, Mo. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 22 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): Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 1-27-1890

7. AGE: Years 46 — Months 6 — Days 18 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

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

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

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

11. Total time (years) spent in this occupation: Unknown

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Orrick, Mo.

FATHER

13. NAME: Dodd Rowland (deceased)

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

MOTHER

15. MAIDEN NAME: Abbit Rowland

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

17. INFORMANT (ADDRESS): Hospital Records

18. BURIAL, CREMATION, OR REMOVAL PLACE: COFFEE MO DATE 9-18-36, 19

19. UNDERTAKER (ADDRESS): John C. Prather, Excelsior Springs, Missouri

20. FILED 9-15-, 1936 Mrs. Rea McCracken, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Sept. 15, 1936 19

22. I HEREBY CERTIFY, That I attended deceased from July 24, 1936, 19, to Sept. 15, 1936, 19

I last saw him alive on Sept. 15, 1936, 19 Death is said to have occurred on the date stated above, at 5:05 m. P.M.

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

	Date of onset
Tuberculosis, pulmonary, chronic, active advanced, bilateral	?

Other contributory causes of importance: 3

Name of operation none Date of --

What test confirmed diagnosis? Exam&Obs. Was there an autopsy? No.

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

Accident, suicide, or homicide? no 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 H. C. Hardegree

(Signed) H. C. HARDEGREE, MD, Clinical Director

(Address) Veterans Administration Facility, Excelsior Springs, Missouri