

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

44820
Do not use this space.

1. PLACE OF DEATH

(a) County Scott ³ Registration District No. 8-1
 (b) Township Richland ¹ Primary Registration District No. 45-53 Registered No. _____
 (c) City Sikeston (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Robert Lee Cowan

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3/23/20

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
19 7 7

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Carpenter
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Cape Gir. (STATE OR COUNTRY) Mo.

FATHER 13. NAME Walter Clark Cowan
 14. BIRTHPLACE (CITY OR TOWN) Shawneetown (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME Ollie Madden
 16. BIRTHPLACE (CITY OR TOWN) Oak Ridge (STATE OR COUNTRY) Mo.

17. INFORMANT Walter C. Cowan (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL Oak Ridge PLACE Locher Cemetery DATE Nov 1 1939

19. FUNERAL DIRECTOR (NAME) McCombs Funeral Co (ADDRESS) Jackson Mo.

20. FILED 12-83 1939 W.A. Merrill Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/30/39 1939

22. I HEREBY CERTIFY, That I attended deceased from 10-30-39 to 10-30-39, 1939
 I last saw him alive on 10-30-39, 1939 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:

Concession of Brain
2. Fracture of skull
 Date of onset 10-30-39

Other contributory causes of importance:

None

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Accident Date of injury 10-30-39
 Where did injury occur? Sikeston, Scott, Missouri
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.
On public highway
 Manner of injury Concession to brain in automobile
 Nature of injury wash to fracture of skull

24. Was disease or injury in any way related to occupation of deceased? None
 If so, specify _____
 (Signed) Merline Anderson M. D.
 (Address) Sikeston, Missouri

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

210 ml
9/25

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
DIVISION OF REGISTRATION

James

RECEIVED

1239-455
12-26

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision,

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

44820
Do not use this space.

1. PLACE OF DEATH *Scott*
 (a) County *Scott* Registration District No. *821*
 (b) Township *Sikeston* Primary Registration District No. *4533* Registered No. _____
 (c) City *Sikeston* (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Robert Lee Coonan*
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *s* (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
19 7 7

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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) _____

FATHER 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19.

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10-30* 19*39*

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
 I last saw h..... 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:
*Constriction of Brain
 Fracture of Cervical Vertebra*
 Date of onset _____

Other contributory causes of importance: *210 m*

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. *Vehicle*
 Manner of injury *Automobile accident*
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify *Yes*
 (Signed) *Merlin G. Anderson* M. D.
 (Address) *Sikeston Mo*

SUPPLEMENTARY

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

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.

