

Registration District No. **6-781**

Primary Registration District No. **5904**

Registrar's No. _____

1. PLACE OF DEATH: **Phelps.**
 (a) County **Phelps.**
 (b) City or town **ST JAMES, MO**
 (c) Name of hospital or institution: **SOLDIERS HOME OF MISSOURI**
 (d) Length of stay: In hospital or institution **15** years, months or days
 In this community **15 YEARS.**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Phelps**
 (c) City or town **ST JAMES.**
 (d) Street No. **0**
 (e) If foreign born, how long in U. S. A. **FOYER** years.

3. (a) PRINT FULL NAME **JANE S. ROWE**
 (b) If veteran, name war
 (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **FEB** day **21**
 year **1940** hour **4** pm minute _____ M.

4. Sex **FEMALE** **5. Color or race** **WHITE**
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **MAY 17, 1849**

21. I hereby certify that I attended the deceased from _____
 _____, 1933, to **Feb 21**, 19**40**,
 that I last saw h^e alive on **Feb 21**, 19**40**,
 and that death occurred on the date and hour stated above.

8. AGE: Years **89** Months **9** Days **4** If less than one day _____ hr. _____ min.
9. Birthplace **WERNER County, PENNSYLVANIA**

Immediate cause of death **Cancer of Liver**
 Duration _____

10. Usual occupation _____
11. Industry or business _____
12. Name **NOT KNOWN**
13. Birthplace _____
14. Maiden name **NOT KNOWN**
15. Birthplace _____

Due to _____
 Due to **410**
 Other conditions (include pregnancy within 3 months of death) _____

16. (a) Informant's own signature **J. D. Reese**
(b) Address **St James, Mo.**
17. (a) HOME CEMETERY (b) Date thereof **2-23-40**
(c) Place: burial or cremation **ST JAMES, MO**
18. (a) Signature of funeral director **John + Leonard**
(b) Address **St James, Missouri**
19. (a) 3-1-1940 (b) **Elaine B. Hoyle**
(Date received local registrar) **1 11** (Registrar's signature)

Major findings: Of operations _____
 Of autopsy **none**
22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence: _____
 (c) Where did injury occur? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **C. H. Smith** (M. D. or other) _____
Address **St James, Mo.** Date signed **2-23**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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.

RECEIVED

District Health Officer No. 5,

Signed.....

License No. 340 310

Licensed Embalmer No.....

Exp. Date 31240

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **775-6**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **678**

Primary Registration District No. **3904**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Phelps**
 (b) City or town **St. James**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Jane S. Rowe**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **w** 6. (a) ~~Single, widowed, married~~
~~divorced~~ **widowed**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased **may - 17 - 1849**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	90	9	4	min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **5-1-1940** (b) **Elvie B. Houck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **July** day **21**
 year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) (e) Means of injury

23. Signature **C. H. Fulbright** (M. D. or other) _____
 Address **St. James** _____

Duration

PHYSICIAN

 Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MAY 17 1940