

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.

Registration District No. 192 96 1940

Primary Registration District No. 3038

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall
(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 20 years years, months or days

8. (a) PRINT FULL NAME Sherrill L. Cowan
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Nancy J. Cowan 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased May 6 1865 (Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 13 If less than one day hr. _____ min. _____

9. Birthplace Hubery Co. Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Labourer

11. Industry or business _____
MOTHER FATHER { 12. Name Henry P. Cowan
13. Birthplace Franklin Ky (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Mary
15. Birthplace Burford Tenn (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Nancy J. Cowan
(b) Address Marshall Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Wheatland Mo.

18. (a) Signature of funeral director Campbell Burr
(b) Address Marshall Mo.

19. (a) 2-21-40 (Date received local registrar) (b) Mary Kent (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline
(c) City or town Marshall (If outside city or town limits, write "RURAL")
(d) Street No. 677 West Clay (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 19 year 1940 hour 6 minute 45 P. M.

21. I hereby certify that I attended the decedent from _____ 1939 to _____ 1940 and that death occurred on the date and hour stated above
that I last saw him alive on Feb 19 1940

Immediate cause of death Acute Infectious Duration 1/2 hrs

Due to _____
Due to 94 W

Other conditions Stomach Ulcers (Include pregnancy within 3 months of death) 5 yrs

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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? No

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Sherrill L. Cowan (M. D. or other) _____
Address Marshall Mo. Date dictated 2/21/40

RECEIVED
Product Health Officer No. 8
Case File Number
3-18-40
Date Filled

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.....

R.W. Campbell....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *R.W. Campbell*.....
Licensed Embalmer No..... *3469*.....
P. O. Address..... *Marshall, Mo*.....

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.