

MAY 15 1940

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

15041
Do not use this space.

1. PLACE OF DEATH
 (a) County Douglas Registration District No. 384
 (b) Township West Plains Primary Registration District No. 4227
 (c) City West Plains or (d) Street No. _____
 (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 3 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Walter Rufus Dowler
 (a) Residence, No. WEST PLAINS MO 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 (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 21-1858

7. AGE YEARS 81 MONTHS 11 DAYS 3 If LESS than 1 day, _____ hrs. or _____ min.

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

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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/24, 1940

22. I HEREBY CERTIFY, That I attended deceased from 3/19, 1940, to 3/24, 1940
 I last saw him alive on 3/24, 1940 Death is said to have occurred on the date stated above, at 1:15 p.m.
 The principal cause of death and related causes of importance were as follows:
Apoplexy - Cerebral - 10 days
 Other contributory causes of importance: 92 hr. Mitral Stenosis

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? No
 If so, specify: _____ (Signed) Maurice Thompson, M. D.
 (Address) West Plains Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Council Bluffs, Iowa

FATHER 13. NAME Joseph Dowler

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

MOTHER 15. MAIDEN NAME Sarah Trice

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

17. INFORMANT (ADDRESS) Nancy Dowler West Plains, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Hill DATE 3/26, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Robinson West Plains, Mo

20. FILED 3-26, 1940 Vida W. SIMONS Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

Thompson

WRITE CLEARLY, 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.

1 X 16003

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.

..... Officer No. 5,

District File Number 540 540

Date Filed 5/10/40

Signed L. W. Roberts

Licensed Embalmer No. 3432

P. O. Address West Haven

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.