

Registration District No. 257

Primary Registration District No. 6738

Registrar's No. 27

1. PLACE OF DEATH:

- (a) County Taney
 (b) City or town Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 7
 (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 days3. (a) PRINT
FULL NAMEJohn Irwin Rowland3. (b) If veteran,
name wasWorld War3. (c) Social Security
No. _____4. Sex Male5. Color or
race White6. (a) Single, widowed, married,
divorced Married6. (b) Name of husband or wife
Carrie E. Rowland6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased April 30 1890
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

35324

hr. min.

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

10. Usual occupation

Farmer

11. Industry or business

12. Name

John Rowland

13. Birthplace

Hallas Mo
(City, town or county) (State or foreign country)

14. Maiden name

Mary Wendling

15. Birthplace

Holtville Mo
(City, town or county) (State or foreign country)

16. (a) Informant's own signature

Carrie E. Rowland

(b) Address

Branson Mo17. (a) Rural(b) Date thereof Aug 15 1925
(Month) (Day) (Year)

(c) Place: burial or cremation

Branson Cemetery

18. (a) Signature of funeral director

Whitehead Fun Home

(b) Address

Branson Mo19. (a) 4-16-1940(b) John M. Barthe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Taney
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Branson Township
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Aug day 14th
year 1925 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death Drowned
while fishing in
Lee Creek

Duration

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)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) Accident(b) Date of occurrence Aug 14th 1925

(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? 77th

While at work? _____ (Specify type of place)

(e) Means of injury county23. Signature J. H. Pharrhill coroner (M. D. or other)Address Branson Mo Date signed 8-15-25

153

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16335-
Registrar's No. 27

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. 859

Primary Registration District No. 6728

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

1. PLACE OF DEATH:
(a) County Laney
(b) City or town Boonville
(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.....
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME John Irwin Rowland
3. (b) If veteran name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 35 Months 3 Days 24 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

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..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4-16-1940 (Date received local registrar) (b) John M. Baxter (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.

20. DATE OF DEATH: Month Aug day 14 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 1940, to....., 19.....; that I last saw him..... alive on..... and that death occurred on the date and hour stated above. Immediate cause of death: drowned while fishing in Bee Creek.

Due to There was no boat involved in this case

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

Major findings: 187
Of operations..... 26
Of autopsy..... 8

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?.....

While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature J. H. Thornhill (M. D. or other) Coroner
Address Season Date signed.....

SUPPLEMENTAL

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

