

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21245**

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **650**

1. PLACE OF DEATH:

Buchanan
(a) County _____
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Donald Lee Cowart** **630**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **June 10 1940**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 2 hr. _____ min.

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **infant**

11. Industry or business _____

MOTHER FATHER
12. Name **Roy Burnett Cowart**
13. Birthplace **Tecumseh Missouri**
(City, town, or county) (State or foreign country)
14. Maiden name **Estella Isabelle Pool**
15. Birthplace **De Kalb Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Roy B. Cowart**
(b) Address **6535 Grant St.**

17. (a) **Burial** (b) Date thereof **June 13, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **De Kalb Mo**

18. (a) Signature of funeral director **Clark Mortuary**
(b) Address **5025 King Hill Ave**

19. (a) **6/13/40** (b) **A. Mestlebusch**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Buchanan** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **6535 Grant**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **12,**
1940 year. hour **1** minute **50 P.** M.

21. I hereby certify that I attended the deceased from **June 10**, 19**40**, to **June 11**, 19**40**;
that I last saw him alive on **June 11**, 19**40**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Prematurity**

Due to _____
Due to **154**

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

Major findings:
Of operations
Of autopsy

Duration
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? _____

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

23. Signatures **W. Roger Moore** (M. D. or other) _____
Address **St. Joseph, Mo.** Date signed **6/13/40**

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

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Earle A. Clark*.....
Licensed Embalmer No. *3476*
P. O. Address..... *St Joseph*.....

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.