

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21482

Registration District No. 163

Primary Registration District No. 5234

Registrar's No. 33

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. PLACE OF DEATH:

(a) County Cedar
 (b) City or town Stockton, Mo. Rural - Mesh.
 (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 9
 (Specify whether

In this community Most of life years, month or days)

3. (a) PRINT FULL NAME Arthur L. Cowan3. (b) If veteran, name war. 3. (c) Social Security No. 4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced M.6. (b) Name of husband or wife Ella Cowan 6. (c) Age of husband or wife if alive 56 years7. Birth date of deceased Feb. 24-1874 (Month) (Day) (Year)8. AGE: Years 66 Months 4 Days If less than one day hr. min. 9. Birthplace Dade County (City, town, or county) (State or foreign country)10. Usual occupation Farming

11. Industry or business

12. Name William R. Cowan 13. Birthplace Dade County (City, town, or county) (State or foreign country)14. Maiden name Aminta Cowan 15. Birthplace Dade County (City, town, or county) (State or foreign country)16. (a) Informant's own signature X R L Cowan 16. (b) Address Stockton, Mo.17. (a) Burial, cremation, or removal Lindley Prairie (b) Date thereof 6-26-40 (Month) (Day) (Year)18. (a) Signature of funeral director W.C. Morris & Co. (b) Address Stockton, Mo.19. (a) Did you receive local registrar's signature Yes (b) Did Minnie Carlton (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cedar

(c) City or town Stockton (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 June day 24 year 1940 hour 2:45 minute 45 M. PM

21. I hereby certify that I attended the deceased from 15 June 1940 to 15 June 1940 that I last saw him alive on 15 June 1940 and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary Occlusion Duration —

Due to Cardio Lung Disease 10 yrs

Due to Emphysema 20 yrs

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

Major findings: Of operations 1/21

Of autopsy

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?

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

23. Signature J. M. Morris (M. D. or other) MM Address Stockton, Mo. Date signed 6-24-40

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, John.....

....., Registered Apprentice No.,
working under my personal supervision.

Signed.....

Melvin Church

Licensed Embalmer No. 3272.....

P. O. Address S. STOCKTON, N.Y.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21482

Registration District No. 165

Primary Registration District No. 5234

Registrar's No.

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

1. PLACE OF DEATH:

(a) County *Cedar County, I.P.*

(b) City or town *(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 *Arthur L. Conner*

3. (b) If veteran,
name war: *W.W.II*

3. (c) Social Security
No. *211-12-1212*

4. Sex *M*

5. Color or
race *W*

6. (a) Single, widowed, married,
divorced *W*

6. (b) Name of husband or wife: *None*

6. (c) Age of husband, or wife, if
alive *None* year

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years *66*

Months *4*

Days *15*

If less than one day
hr. *11* min. *55*

9. Birthplace *Missouri*

(City, town, or county)

(State or foreign country)

10. Usual occupation: *None*

11. Industry or business: *None*

FATHER 12. Name: *None*

13. Birthplace: *None*

(City, town, or county)

(State or foreign country)

14. Maiden name: *None*

MOTHER 15. Birthplace: *None*

(City, town, or county)

(State or foreign country)

16. (a) Informant: *None*

(b) Address: *None*

17. (a) *None* (b) Date thereof: *None*

(Month) (Day) (Year)

(c) Place: burial or cremation: *None*

18. (a) Signature of funeral director: *None*

(b) Address: *None*

19. (a) *None* (b) *None*

Date received by local registrar

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *None* (b) County *None*

(c) City or town *None* (If outside city or town limits write "RURAL")

(d) Street No. *None* (If rural, give location)

(e) If foreign born, how long in U. S. A.? *None* years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *24*

year *1948* hour *12* minute *00* M.

21. I hereby certify that I attended the deceased from

None 19th to *None* 19th; *None* 19th to *None* 19th;

that I last saw him *None* alive on *None*

and that death occurred on the date and hour stated above.

Immediate cause of death: *None*

Due to: *None*

Due to: *None*

Other conditions: *None*
(Include pregnancy within 3 months of death)

Major findings:
Of operations: *None*

Of autopsy: *None*

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): *None*

(b) Date of occurrence: *None*

(c) Where did injury occur? *None*

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *None*

While at work? *None* (Specify type of place) *None* Means of injury: *None*

23. Signature: *James Flaherty* M. D. or other: *None*

Address: *Stockton* Date signed: *None*

Underline
the cause to
which death
should be
charged sta-
tistically.

