

Registration District No. **702**

Primary Registration District No. **5934**

Registrar's No. **7**

1. PLACE OF DEATH:
(a) County Polk
(b) City or town Halfway
(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 ALL HER LIFE years, months or days

8. (a) PRINT FULL NAME IDA MAE ROWETON
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife T.J. ROWETON
6. (c) Age of husband or wife if alive 68 1/2 years
7. Birth date of deceased APRIL 11 1876 (Month) (Day)

8. AGE: Years 66 Months 5 Days 4 If less than one day hr. _____ min.

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

10. Usual occupation HOUSE WIFE 9

11. Industry or business _____

12. Name S.L. BAILEY 9

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

14. Maiden name JANE JACKSON

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

16. (a) Informant's own signature T.J. ROWETON

(b) Address HALFWAY

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Sept 17 1940 (Month) (Day) (Year)

(c) Place: burial or cremation REED

18. (a) Signature of funeral director HUTCHESON & CO

(b) Address BOLIVAR MISSOURI

19. (a) 9-18-40 (Date received local registrar) (b) Mary Lane (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County POLK
(c) City or town HALFWAY (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 Sept day SUNDAY year 1940 hour 5:30 minutes P.M.

21. I hereby certify that I attended the deceased from Sept 5 1940 to Sept 15 1940 that I last saw him alive on July 15 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary artery stenosis

Due to _____

Due to 46

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

634 (Specify type of place) (e) Means of injury _____

23. Signature W.C. Smith (M. D. or other) _____

Address Bolivar Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7,

District File Number 10-40-1445

Date Filed 10-9-40

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, 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. **32894**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **705**

Primary Registration District No. **5934**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Polk**
(b) City or town **Benton Twp.**
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Ida Mae Roweton**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased **Apr 11 1888**
(Month) (Day) (Year)

8. AGE: Years **66** Months **5** Days **4** 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **9-18-40** (b) **Mary Lomel**
(Date received local registrar) (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 **Sept** day **15**
year _____ 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 _____

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

Major findings:
Of operations _____
Of autopsy _____

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 **G. D. Smith** (M. D. or other) _____
Add **Bellevue Mo** Date signed _____

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

SUPPLEMENTAL

