

No. 2
13-40
17-39
X23159

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: Missouri Pacific Hospital
(d) Length of stay: In hospital or institution 7 months
In this community 7 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County St. Clair
(c) City or town Pays
(d) Street No. _____
(e) If foreign born, how long in U. S. A.? 2 years

3. (a) PRINT FULL NAME: George Wallace Rowland
(b) If veteran, name war None
(c) Social Security No. 702-18-1680

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 13
year 1941 hour 10 minute 35 P.M.

4. Sex Male () 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Carrie
6. (c) Age of husband or wife if alive 66 years

21. I hereby certify that I attended the deceased from 4/27/41, 19____, to 6/13/41, 19____;
that I last saw him 12 alive on 6/13/41, 19____;
and that death occurred on the date and hour stated above.

7. Birth date of deceased Aug 10 1868
(Month) (Day) (Year)

Immediate cause of death Carcinoma of Colon

8. AGE: Years 72 Months 10 Days 3
If less than one day hr. _____ min. _____

Due to _____
Due to _____

9. Birthplace Cynthiana Kentucky
(City, town, or county) (State or foreign country)
10. Usual occupation Special Agent
11. Industry or business Missouri Pacific Rail Road

Other conditions None
(Include pregnancy within 3 months of death)
Major findings: Carcinoma of Ascending Colon

12. Name Carrie Rowland
13. Birthplace Cynthiana Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

Of operations _____
Of autopsy _____

16. (a) Informant Oscar Rowland
(b) Address Super Ill
17. (a) removal (b) Date thereof 6-13-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation removal to Pays - Ill
18. (a) Signature of funeral director Paul A. Williams
(b) Address Pays Ill
19. (a) JUN 23 1941 (b) L. F. Broach
(Date received local registrar) (Registrar's signature)

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. Signature Charles C. Drace (M. D. or other) M.D.
Address 1755 So Grand Date signed 6/13/41

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

110
17
4

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

5134

5134

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 Me

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

Signed B en H Baldwin

Licensed Embalmer No. 2470

P. O. Address C St Louis, Ill.

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, fact should be so stated above.