

FILED OCT 16 1941

Registration District No. 689

Primary Registration District No. 5917

Registrar's No.

1. PLACE OF DEATH:
(a) County Pike Co. Mo
(b) City or town Red-Clarksville Mo
(c) Name of hospital or institution Buffalo Township
(d) Length of stay: In hospital or institution 3 days
In this community 1 years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Okla (b) County Pawnee 999
(c) City or town Quay
(d) Street No. 34
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME James Henry Trower
(b) If veteran, name war No
(c) Social Security No. Yes 444-10-5862

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month Sept day 07 year 1941 hour prior minute 1200 P.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.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
7. Birth date of deceased Apr 10 1877 (Month) (Day) (Year)

Immediate cause of death Natural Causes
Duration _____

8. AGE: Years 64 Months 4 Days 27 If less than one day hr. min.

Due to _____
Due found dead in bed

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

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation Farmer

MOTHER FATHER
11. Industry or business _____
12. Name Frank Trower
13. Birthplace Pike Co Mo
14. Maiden name Lidia Lafferty
15. Birthplace: Andrain Co Mo

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)
Means of injury _____

16. (a) Informant J. Cantrell
(b) Address Quay, Okla. Seminole Okla
17. (a) Burial (b) Date thereof 9-10-41
(c) Place: burial or cremation Blackburn Okla
18. (a) Signature of general director J. H. Hays
(b) Address Louisiana Mo
19. (a) 9-8-41 (b) J. Hays
(Date received local registrar) (Registrar's signature)

23. Signature M. Smith Coroner
Address Louisiana Mo Date signed 9/8/41

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

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17-39 X26390

RECEIVED

District Health Officer No. 10

District File Number 10-41-1839

Date Filed OCT 13 1941

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.....

.....
working under my personal supervision.

Signed

George O. Wagner
....., Registered Apprentice No.

Licensed Embalmer No. 3773

P. O. Address Louisiana

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32290
Registrar's No. _____

Registration District No. 689

Primary Registration District No. 5917

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Rural
(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 James H. Trower
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 _____ years
7. Birth date of deceased Apr 10 1877
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 14 (If less than one day min.)
9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry of business _____
MOTHER FATHER { 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) _____ (b) _____
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Coronary thrombosis
Due to Found dead in bed

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

Major findings: Of operations 94a
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) (e) Means of injury _____

23. Signature Mr. Smith Crowner
(M.D. or other) (M.D. or other)
Address Louisiana, Mo. Date signed 9/18/41

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

SUPPLEMENTARY

