

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15442  
Registrar's No. 30

Registration District No. 6028

Primary Registration District No. 6028

1. PLACE OF DEATH

(a) County Ste. Genevieve  
(b) City or town Rural Jackson Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Danby Star Route  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ste Genevieve  
(c) City or town Rural Jackson Twp  
(If outside city or town limits, write "RURAL")  
(d) Street No. Danby Mo Star Route  
(If rural, give location)  
(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29  
year 1942 hour 1 minute 45 P. M.  
21. I hereby certify that I attended the deceased from April 4  
1942 to April 29 1942  
that I last saw him alive on April 27 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Multiple Sclerosis  
Duration 6 months

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 D  
23. Signature Arthur S. Chapman (M. D. or other) MD  
Address St. Genevieve Mo Date signed 5-30-42

3. (a) PRINT FULL NAME ROBEN TOYE VOWELL  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 496-10-4767

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Maysie F. Vowell 6. (c) Age of husband or wife if alive 68 years  
7. Birth date of deceased December 9 1869  
(Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Franklin Tenn  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Robert Vowell

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

14. Maiden name Elizabeth Hanges

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

16. (a) Informant Maysie F. Vowell

(b) Address Danby Mo Star Route

17. (a) Burial (b) Date thereof May 1-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cornard Cemetery

18. (a) Signature of funeral director Jerry Stanton Mortuary

(b) Address Ste Genevieve Mo  
19. (a) Apr 30/42 (b) T. W. Douglas  
(Date received local registrar) (Registrar's signature)

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

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MAY 11 1949

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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 *L. Roy J. Schindler*  
Licensed Embalmer No. *4175*  
P. O. Address *Perryville, Mo.*

**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.**