

FILED AUG 13 1942

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

23904

Do not use this space.

1. PLACE OF DEATH

(a) County BUCHANAN Registration District No. 85
 (b) Township Primary Registration District No. 1001
 (c) City ST. JOSEPH or (d) Street No. ST. JOSEPH HOSPITAL St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. 5 (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Rowe, Mr. Ray

(a) Residence, No. Savannah, Missouri St. Savannah mo Rural
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-1-1908

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 1 8

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bolexow Mo13. NAME William Rowe14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Savannah Mo15. MAIDEN NAME Nettie Davidson16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Savannah Mo17. INFORMANT (ADDRESS) Mrs. Chas. M. Carty Savannah Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Savannah Mo DATE July 11 194219. FUNERAL DIRECTOR (NAME) (ADDRESS) J. Fred Lawrence Savannah Mo20. FILED 7-10 1942 Rose Herzog Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 9 1942

22. I HEREBY CERTIFY That I attended deceased from June 15 1942 to July 9 1942, 19...
 I last saw him alive on July 9 1942. Death is said

to have occurred on the date stated above, at m.
 The principal cause of death and related causes of importance were as follows:

Secondary - post-operative shock
 Date of onset

Other contributory causes of importance: MI

Name of operation Cholecystectomy + appendectomy Date of: 7-6-42
 What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19...
 Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify

(Signed) W. P. Ryan M. D.
 (Address) St. Joseph Mo

1233

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

I X18605

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.

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 Fred Terhune
Licensed Embalmer No. 1279
P. O. Address Savannah

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.