

Registration District No. **1** Primary Registration District No. **3000** Registrar's No. **110**

1. PLACE OF DEATH:
(a) County **Adair**
(b) City or town **Kirksville**
(c) Name of hospital or institution: **Community Nursing Home**
(d) Length of stay: **5 days**
In this community **23 years.**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Adair**
(c) City or town **Kirksville**
(d) Street No. **None**
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Percy A. Rowe**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Apr.** day **27**
year **1943** hour **6:30** minute **P.** M.

3. (b) If veteran, name war. 3. (c) Social Security No. **None**

21. I hereby certify that I attended the deceased from **April 27** to **April 27**, 19**43**, that I last saw him alive on **April 27**, 19**43**, and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or Race **W** 6. (a) Single, widowed, married, divorced, **Widowed**

Immediate cause of death **Myocardial failure**

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. **7** years **1863**

Due to **Coronary Atherosclerosis**

7. Birth date of deceased. **August 7** (Month) (Day) (Year)

Due to **Hypertension**

8. AGE: Years Months Days If less than one day

Other conditions **None**
Major findings: Of operations **No operation**
Of autopsy **No autopsy**

9. Birthplace **Bloomfield Wisc.**
10. Usual occupation **Farmer**

11. Industry or business
12. Name **Franklin Rowe**
13. Birthplace **Onodago New York**
14. Maiden name **Marv Elizabeth Noyes**
15. Birthplace **Hebron Ill.**

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

16. (a) Informant **Mrs. Chas. Tindall**
(b) Address **Kirksville, Mo.**
17. (a) **Burial** (b) Date thereof **4/29/43**
(c) Place: burial or cremation **Lake Park, Iowa**

23. Signature **A. R. Schmitt** (M. D. or other) **D.O.**
Address **Community Planning Unit** Date signed **4/28/43**

18. (a) Signature of funeral director **J. E. Kelly**
(b) Address **Kirksville, Mo.**
19. (a) **4/28/43** (b) **Mrs. J. A. Wasson**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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

APR 30 1949

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 DEE Riley

Licensed Embalmer No. 4181

P. O. Address Reskille MD

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.