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Dr. A. Knabb
31530

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 762

FD SEP 25 1943
Registration District No. 28

Primary Registration District No. 2000

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

1. PLACE OF DEATH:

(a) County Greene
Springfield

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 846 S. Kansas
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 Years
(Specify whether years, months or days)

In this community 30 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 029

(c) City or town Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. 846 S. Kansas
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME George Dowell

3. (b) If veteran, name war No 3. (c) Social Security No. unk

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Josephine Dowell 6. (c) Age of husband or wife if alive dec. years

7. Birth date of deceased March 3 1864
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13
year 1943 hour 11 minute 05 P.M.

21. I hereby certify that I attended the deceased from Aug. 30
1943 to Sept 13 1943
that I last saw him alive on Sept 13 1943
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>79</u>	<u>6</u>	<u>10</u>	hr. min.

Immediate cause of death Coronary artery occlusion this

Due to arterial sclerosis

Due to _____

9. Birthplace Unk. Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

Other conditions Ch. degenerative Cardiovascularis
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy 930

MOTHER FATHER {

12. Name Calvin Dowell

13. Birthplace Unk. Missouri 0
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace Unk. Tennessee 1
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Robert Dowell
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Sept. 16, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eastlawn

18. (a) Signature of funeral director H.H. Lohmeyer
Springfield, Mo.

(b) Address _____

19. (a) 9-15-43 (b) J. W. Handy
(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 _____

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?
(Specify type of place)

While at work? _____
(Specify type of place)

23. Signature Arthur Knapp (M. D. or other) MD
Address 450 1/2 E. Olive Date signed 9-15-43

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

Walter E. Hamble

Licensed Embalmer No.

3808

P. O. Address

Springfield, 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.