

S. No. 2  
4-8-43  
5-17-39  
PI X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED OCT 9 1944**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**30812**

State File No. ....

Registration District No. .... Primary Registration District No. **5350** Registrar's No. ....

**1. PLACE OF DEATH:**  
(a) County **Dallas**  
(b) City or town **Urbana Lincoln**  
(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) **1**  
(d) Length of stay: In hospital or institution. **1** (Specify whether  
In this community **life**  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **Dallas**  
(c) City or town **Urbana**  
(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 .....

**3. (a) PRINT FULL NAME** **RICHARD SIMPSON FOWLER**  
3. (b) If veteran, name war ..... 3. (c) Social Security No. ....

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **8** day **26**  
year **1944** hour **5** minute **20 A.M.**

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Sarah** 6. (c) Age of husband or wife if  
alive **69** years  
7. Birth date of deceased **8 30 1868**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from  
**July 1**, 19**44**, to **Aug 26**, 19**44**  
that I last saw him alive on **Aug 22**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Shuntic myeloditis** Duration **2 1/2**

**8. AGE:** Years **75** Months **11** Days **26** If less than one day  
hr. .... min.

Due to .....  
Due to .....

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

Other conditions (Include pregnancy within 3 months of death) **928**

**10. Usual occupation** **Miller Retired**

**11. Industry or business** .....

**MOTHER FATHER**  
12. Name **James Fowler**  
13. Birthplace **Ky**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Mary Bernal**  
15. Birthplace **Tenn**  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations .....  
Of autopsy .....

**16. (a) Informant** **Robert Fowler**  
(b) Address **Urbana Mo**  
**17. (a) Bernal** (b) Date thereof **8-29-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

**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? .....

**18. (a) Signature of funeral director** **R B Jones**  
(b) Address **Buffalo Mo**  
**19. (a) 10-1-44** (b) **R B Jones**  
(Date received local registrar) (Registrar's signature)

While at work? ..... (Specify type of place)  
(c) Means of injury .....  
**23. Signature** **R B Jones** (M. D. or other) **MD**  
Address **26 Urbana Mo** Date signed **Aug 26 1944**

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

1371

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7,

District File Number 9-44-1127

Date Filed 2/6-6-44

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

*Wm. B. Jones*

Licensed Embalmer No. 4312

P. O. Address *Buffalo, N.Y.*

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.