No. 2
1-4-41
17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 21 1944

Registration District No. 11

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 302 A

30843

State File No.

Registrar's No.

1. PLACE OF DEATH:
(a) County: Franklin
(b) City or town: Washington Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 15 Days (Specify whether years, months or days)
In this community: 66 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Franklin
(c) City or town: Pacific (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: ✓

3. (a) PRINT FULL NAME: Alfreeden Fowler

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

4. Sex: Female
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: March (Month) 2 (Day) 1878 (Year)

8. AGE: Years 66 Months 6 Days 8 If less than one day hr. min.

9. Birthplace: Labadie (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER
12. Name: Edward Hinkle
13. Birthplace: Labadie (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name: Mary Woods
15. Birthplace: (City, town, or county) Mo (State or foreign country)
16. (a) Informant: Mrs Mary Taylor
(b) Address: 408 E. Second St. Washington Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-14-1944 (Month) (Day) (Year)
(c) Place: burial or cremation:
18. (a) Signature of funeral director: John N. Hemphill
(b) Address: 408 S. Filmore Ave Washington Mo
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11 year 1944 hour 10:00 minute A. M.
21. I hereby certify that I attended the deceased from Aug 27, 1944, to Sept 11, 1944, that I last saw her alive on Sept 11, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death: Severe Toxemia — Duration 1 Mo
result of Pericaval abscess and cellulitis of left back and thigh (Tuberculosis)
Due to:
Due to:
Other conditions: Diabetes Mellitus — Duration Some
(Include pregnancy within 3 months of death)

Major findings: Large Pericaval abscess — cellulitis of right back and thigh
Of operation:
Of autopsy: No

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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: R. R. Quela M.D. (M. D. or other)
Address: Washington, Mo. Date signed: 9/12/44

1181

(Licensed Embalmer's Statement on Reverse Side)

SEP 25 1944

RECEIVED
District Health Officer No. 9,

District File Number

Date Filed 9-18-44

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 myself, Registered Apprentice No. working under my personal supervision.

Signed R. C. Houston Jr.

Licensed Embalmer No. 2266

P. O. Address 2812, Thomas St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 116 Primary Registration District No. 3020 Registrar's No.

1. PLACE OF DEATH:

(a) County: Franklin.

(b) City or town: Washington, Mo.
(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)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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: Alfreeden Fowler

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

5. Color or race: B

6. (a) Single, widowed, married, divorced: W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive (Years)

7. Birth date of deceased: March (Month) 2 (Day) 1898 (Year)

8. AGE: Years 66 Months 6 Days If less than one day: hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) Lucile R. Brooks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. Day 4 Year 1944 Hour Minute M.

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

Immediate cause of death — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

30843