No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1944

Registration District No. 248

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3047

State File No. 31390

Registrar's No. 103

1. PLACE OF DEATH:

(a) County Newton

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

(c) Name of hospital or institution: Sale Memorial Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days 0 (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton

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

(d) Street No. 312 Wheeler (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Annie Rowe

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife U. S. Rowe

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

7. Birth date of deceased April (Month) 26 (Day) 1875 (Year)

8. AGE:

Years	Months	Days	If less than one day
69	4	21	hr. min.

9. Birthplace (City, town, or county) 5 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

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

MOTHER
14. Maiden name Not Known
15. Birthplace (City, town, or county) Not Known (State or foreign country)

16. (a) Informant Maude Smith

(b) Address Neosho Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept (Month) (Day) 1944 (Year)

(c) Place: burial or cremation IOOF Cemetery

18. (a) Signature of funeral director J A Bingham

(b) Address Neosho Missouri

19. (a) 9-25-1944 (Date received local registrar) (b) Carly Thompson (Registrar's signature)

1110

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17 year 1944 hour 4 minute A M.

21. I hereby certify that I attended the deceased from , 19 , to Sept 17 , 1944 that I last saw her alive on Sept 17 , 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Respiratory Failure	72 hrs
Cardiac Decompensation	72 hrs.
Due to Secondary Anemia	3 yrs
Due to Cause Unknown	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

95 CV

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 Robert A Hershew Jr (M. D. or other) MD

Address Neosho Missouri Date signed 9/18/44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED OCT 5 1944

District Health Officer No.

District File Number 944-196

Date Filed OCT 5 1944

RECEIVED

District Health Officer No.

District File Number

Date Filed

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 J. W. Bigham

Licensed Embalmer No. 2689

P. O. Address Neosho 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.

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. Oct.

Registration District No. 245 Primary Registration District No. 3047 Registrar's No. 103

1. PLACE OF DEATH:
(a) County Newton
(b) City or town Neosho.
(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 Missouri (b) County Newton
(c) City or town Neosho
(If outside city or town limits, write "RURAL")
(d) Street No. 312 Wheeler
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Annie Rowe
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
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 April 26 1878 (Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days If less than one day hr. min.

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

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) 10-12-44 (Date received local registrar) (b) Cooley Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 7 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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

31390