

Registration District No. **316** Primary Registration District No. **6075**

**1. PLACE OF DEATH:**  
(a) County **St. Francois**  
(b) City or town **Farmington RURAL St. Francois**  
(c) Name of hospital or institution:  
**Mo. State Hospital No. 4**  
(d) Length of stay: In hospital or institution **16 yrs., 8 mos., 14 das.**  
In this community **16** years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **Phelps**  
(c) City or town **Edgar Springs**  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? **No**

**3. (a) PRINT FULL NAME** **DAVID LINDSAY COWAN**  
(b) If veteran, name war **Unknown** (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **May 19 1891**  
(Month) (Day) (Year)

8. AGE: Years **53** Months **6** Days **20**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Relfe Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

**11. Industry or business**  
12. Name **Robert B. Cowan**  
13. Birthplace **Edgar Springs Missouri**  
14. Maiden name **Sallie B. Coppedge**  
15. Birthplace **Relfe Missouri**

16. (a) Informant **Records of State Hospital No. 4**  
(b) Address **Farmington, Missouri**

17. (a) **Burial** (b) Date thereof **12-12-44**  
(c) Place: burial or cremation **Cowan Cem., Edgar Springs, Mo.**

18. (a) Signature of funeral director **Null Funeral Home**  
(b) Address **Rolla, Missouri**

19. (a) **1-3-45** (b) **James Robinson**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month **Dec.** day **9th**  
year **1944** hour **2** minute **40 P.M.**  
21. I hereby certify that I attended the deceased from **March 6, 1942**, to **Dec. 9, 1944**  
that I last saw him alive on **Dec. 9, 1944**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Para Typhoid Fever, Type A** Duration **1 Mo.**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions: **Terminal Hypostatic Pneumonia**  
(Include pregnancy within 3 months of death) **47 days**

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy: **Para Typhoid Fever**  
**Hypostatic Pneumonia**

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? **Mo.**

23. Signature **Frank Nichols** (M. D. \_\_\_\_\_)  
Address **Farmington, Mo.** Date signed **12-9-44**

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

MOTHER FATHER

Sanitary Health Officer No. 4

District File Number 145-116

Date Filed 1-16-48

**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 me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

*For Miller Funeral Home*

Signed C J Hayes

Licensed Embalmer No. 13527

P. O. Address Farmington 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.**