

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1296A  
Registrar's No. 121

Registration District No. 43

Primary Registration District No. 4057

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

1. PLACE OF DEATH:

(a) County Butler

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

(c) Name of hospital or institution:  
general delivery /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no (Specify whether years, months or days)

In this community 3 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler

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

(d) Street No. general delivery  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sira Elizabeth Fowler

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Charlie Fowler

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased April 3 1881  
(Month) (Day) (Year)

8. AGE: Years 64 Months - Days 14 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business none

12. Name Robert Beggs

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Charlie Fowler

(b) Address Quin, Missouri

17. (a) Burial (b) Date thereof 4-18-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malden Memorial Park

18. (a) Signature of funeral director Day Funeral Home

(b) Address Malden, Missouri

19. (a) 4-23-45 (b) Belle Dinnel  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16 th  
year 1945 hour 6 minute 00 P.M.

21. I hereby certify that I attended the deceased from 4-4, 1945, to 4-16, 1945  
that I last saw him alive on 4-15, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death cardiac & chronic degenerative

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address [Address] Date signed \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MAY 4 1949

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. Schuman  
Licensed Embalmer No. 4086  
P. O. Address Malden

**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.