

FILED DEC 28 1945

STANDARD CERTIFICATE OF DEATH

State File No. **42141**

Registration District No. **277**

Primary Registration District No. **4411**

Registrar's No. **61**

1. PLACE OF DEATH

(a) County **Pike**
(b) City or town **Bowling Green**
(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
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Pike 82**
(c) City or town: **Bowling Green** /
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Dorothy Ann Harlow**

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 **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 28 1870**
(Month) (Day) (Year)

8. AGE: Years **75** Months **7** Days **28** If less than one day hr. _____ min. _____

9. Birthplace **Rockport Illinois /**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____
12. Name **Thomas Demoin**
13. Birthplace **Ohio /**
(City, town, or county) (State or foreign country)
14. Maiden name **Rebecca Roberts**
15. Birthplace **Ohio /**
(City, town, or county) (State or foreign country)

16. (a) Informant **Demoin & Harlow**
(b) Address **Bowling Green, Mo**
17. (a) **Burial** (b) Date thereof **11/26/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Rockport Ill**
18. (c) Signature of funeral director **Shale Banthead**
(b) Address **Bowling Green Mo.**
19. (a) **Dec 3, 1945** (b) **Bill Robinson**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **26**
year **1945** hour **10** minute _____ P. M.

21. I hereby certify that I attended the deceased from **1940**
_____, 19____, to **11/26**, 19____
that I last saw h. **u** alive on **11/26/45**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Crownary Thrombus 30 Months**
Due to **Endocarditis Chornal** **yes**
Due to **Myocarditis Chornal** **no**
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **1940**
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?
While at work? _____ (Specify type of place) (M. D. or other):
23. Signature **M. Mathias** (M. D. or other):
Address **Bowling Green** Date signed **11/27/45**

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

SEP 26 1958

DEC 29 1945

RECEIVED

District Health Officer No. 10

District File Number 12-45-1919

Date Filed DEC 29 1945

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 *Grace W. Banfield*

Licensed Embalmer No. *2204*

P. O. Address *Bowling Green*

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.