

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 9 1946

State File No. **24246**
Registrar's No. **90**

Registration District No. **187** Primary Registration District No. **5698**

1. PLACE OF DEATH:
(a) County **Livingston**
(b) City or town **Rural Jackson Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6 miles N.W. Chillicothe, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **86 years.**
years, months or days

3. (a) PRINT FULL NAME **ELIJA RICHARD DOWELL**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Mary Jane Dowell**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 7 1855**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	91	4	20	hr. _____ min.

9. Birthplace **Van Buren Iowa**
(City, town, or county) (State or foreign country)
10. Usual occupation **Minister**

11. Industry or business _____
12. Name **Elija Roundtree Dowell**
13. Birthplace **Frankfort Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary F. Hayden**
15. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ben Dowell**
(b) Address **R. F. D. Chillicothe, Mo.**
17. (a) **Burial** (b) Date thereof **7-30-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Brassfield**

18. (a) Signature of funeral director **Norman Funeral Home**
(b) Address **Chillicothe, Missouri**
19. (a) **July - 28 - 46** (b) **Frances B. Neill**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Livingston**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **6 miles N.W. Chillicothe**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **27th**
year **1946** hour **1** minute **P.** M.
21. I hereby certify that I attended the deceased from **Dec. 10, 1940**
July 27, 1946 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 _____
Myocarditis (chronic)
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations **93d**
Of autopsy _____

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 **W. J. Davis** (M. D. or other) _____
Address **Chillicothe, Mo.** Date signed **7/29/46**

Duration **2**
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER

171

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *Elton J. Norman*

Licensed Embalmer No. 4036.....

P. O. Address *Chillicothe, Mo.*

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

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

Registration District No. 167

Primary Registration District No. 5698

1. PLACE OF DEATH:
(a) County Livingston
(b) City or town Rural
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Elyza R. Douell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased mar (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 91 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

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

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

19. (a) July - 28 - 1896 (Date received local registrar) Frances B. Neal (Registrar's signature)

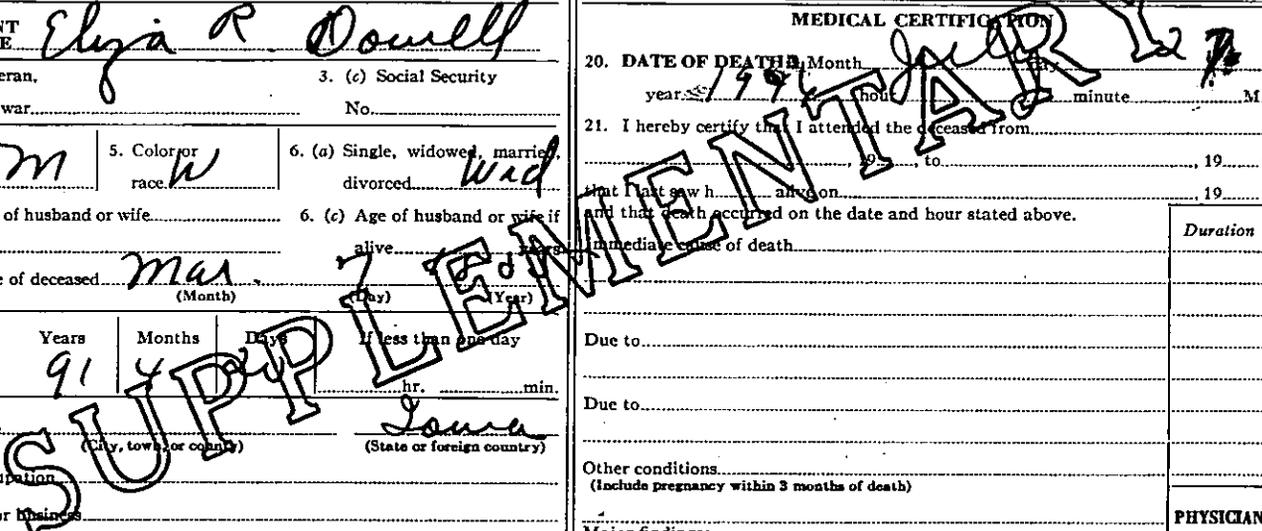
2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month _____ year 1916 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 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 _____
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

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



24246