

Registration District No. **324**

Primary Registration District No. **6092**

Registrar's No. **61**

1. PLACE OF DEATH:

(a) County **SALINE**
(b) City or town **MALTA BEND 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 **22 YEARS**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **SALINE 97**
(c) City or town **MALTA BEND RURAL 0**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **3**
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **LOUISA ELIZABETH FOWLER**

3. (b) If veteran, name war (c) Social Security No.

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW 2**

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

7. Birth date of deceased **OCTOBER 13 1868**
(Month) (Day) (Year)

8. AGE: Years **78** Months **5** Days **12** If less than one day hr. min.

9. Birthplace **CARROLL COUNTY ARKANSAS**
(City, town, or county) (State or foreign country)

10. Usual occupation **RTIRKA**

11. Industry or business _____

12. Name **ADRIAN HOBBS 9**

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

14. Maiden name **MARGARET SPELL**

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

16. (a) Informant **MRS. ELYA ELIOTT**

(b) Address **MALTA BEND MO**

17. (a) ~~MALTA BEND~~ (b) Date thereof **MAR 25 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MOUNT. NERO CEMETERY**

18. (a) Signature of funeral director **E. S. JAMES**

(b) Address **CONCORDIA MO**

19. (a) **Mar 25 1947** (b) **Edmund Gray**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MARCH** day **22**
year **1947** hour **3** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **1/14**
19**47** to **3/22/47**, 19____;
that I last saw her alive on **3/22/47**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Senility**

Due to **Chronic myocarditis**
chronic interstitial
Due to **nephritis**

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations **BIB**
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?

(Specify type of place)
While at work? _____ (e) Means of injury **2**

23. Signature **Geo J James** (M. D. or other) **MD**
Address **Waverly** Date signed **3/24/47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

385

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 4-15-47

MAY 2 1947

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.

Signed E. S. James
Licensed Embalmer No. 2058
P. O. Address Concordia, 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.