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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 20 1947

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. 34195

Registrar's No. 810-A

39
2
6
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
446 South Grant Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 70 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 34
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No. 446 South Grant Avenue 6
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ROBERT MOSBY COWAN
3. (b) If veteran, name war _____ 3. (c) Social Security No. 491-03-9549

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month September day 13,
year 1947 hour 4: minute 00 P. M.

4. Sex Male 0 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Agnes Dade Cowan 6. (c) Age of husband or wife if alive Unknown years
7. Birth date of deceased May 27, 1872
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1, 1947 to Sept 13, 1947
that I last saw him alive on an Sept 2, 1947
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
75 3 16 hr. min.

Immediate cause of death Cerebrary thrombosis
Due to Irregular Death
Due to decrease

9. Birthplace Auxvasse, Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Insurance agent
11. Industry or business Life Insurance

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____
Duration _____

MOTHER FATHER {
12. Name Reverend John F. Cowan
13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Martha Grant
15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Agnes Dade Cowan (wife)
(b) Address 446 South Grant Avenue

While at work? _____ (Specify type of place) (e) Means of injury 0
23. Signature W. E. Handley M.D. (M. D. or other)
Address Springfield, Mo. Date signed Oct 14 1947

17. (a) Burial (b) Date thereof 9/15/1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hazelwood Cemetery
18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri
19. (a) 10-10-47 (b) _____
(Date received local registrar) (Registrar's signature)

OCT 20 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.....

Lee Mason....., Registered Apprentice No. *477*
working under my personal supervision.

Signed *Jewell E. Wendle*.....

Licensed Embalmer No. *2831*.....

P. O. Address *Springfield 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.