

FILED AUG 31 1948

Registration District No. ....

Primary Registration District No. 5019

Registrar's No. 257

## 1. PLACE OF DEATH:

(a) County Andrew  
 (b) City or town Rochester  
 (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: 60 yrs. (Specify whether  
 years, months or days)

3. (a) PRINT FULL NAME Julius Kowitz3. (b) If veteran, name war. no 3. (c) Social Security No. no

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced. wid  
 6. (b) Name of husband or wife. Barbara Nienselman 6. (c) Age of husband or wife if alive. 80 years  
 7. Birth date of deceased. March 25 1861  
 (Month) (Day) (Year)

8. AGE: Years Months Days .. If less than one day  
87 4 20 hr. min.9. Birthplace. No Record Germany  
 (City, town, or county) (State or foreign country)10. Usual occupation: Farmer

## 11. Industry or business:

12. Name Fredricka Kowitz  
 13. Birthplace No Record Germany  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Caroline Beaman  
 15. Birthplace No Record Germany  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Barbara Kowitz  
 (b) Address Savannah Mo17. (a) B (b) Date thereof 8-17-48  
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Savannah18. (a) Signature of funeral director E. C. Beck  
 (b) Address Savannah Mo19. (a) 8-18-48 (b) Lillian Spark  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Andrew  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. R. R. 3 Savannah Mo  
 (If rural, give location)  
 (e) Citizen of foreign country? ..... (Yes or No)  
 If yes, name country .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15  
 year 1948 hour 1 minute 50 A.M.21. I hereby certify that I attended the deceased from 5-27-47  
 ....., 19....., to 8<sup>th</sup> 14 ....., 1948  
 that I last saw him alive on 7-24 ....., 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death.....

Cancer of Prostate 6 yrs.

Due to.....

Due to.....

Other conditions.....  
 (include pregnancy within 3 months of death)Major findings:  
 Of operations.....

Of autopsies.....

## 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.....

23. Signature Lillian B. Spark (M. D. or other) MDAddress Savannah Mo Date signed 8-16-48

MOTHER FATHER

PHYSICIAN

Underline the cause of which death should be charged statistically.

MAR 28 1958

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..... *E. C. Breit* .....

Licensed Embalmer No. *2650*

P. O. Address..... *Savannah* .....

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.