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10-47
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FILED OCT 19 1948

State File No. _____

Registration District No. 137

Primary Registration District No. 3023

Registrar's No. 212

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Moore's Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yrs (Specify whether years, months or days)

In this community 3 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry

(c) City or town Clinton
(If outside city or town limits, write "RURAL")

(d) Street No. 901 N 2nd St
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME Robert Fowler

3. (b) If veteran, name war: —

3. (c) Social Security No. 490-18-5362

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12
year 1948 hour 8 minute 00 P.M.

21. I hereby certify that I attended the deceased from 6/28, 1947 to 10/12, 1948
that I last saw him alive on 10-11, 1948
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased: 2 22 1870
(Month) (Day) (Year)

Immediate cause of death: Pulmonary Edema

Due to Atherosclerosis

Due to _____

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

Major findings: _____

Of operations: _____

Of autopsy: _____

8. AGE: Years Months Days If less than one day

78 7 20 _____ hr. _____ min.

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

10. Usual occupation: Stone mason

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business: _____

12. Name: Geo. Fowler

13. Birthplace: Scotland
(City, town, or county) (State or foreign country)

14. Maiden name: Isabelle McFinger

15. Birthplace: Scotland
(City, town, or county) (State or foreign country)

16. (a) Informant: Marion Chaney
(b) Address: Clinton Mo

17. (a) Burial (b) Date thereof: 10-15-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Cedar Grove

18. (a) Signature of funeral director: S. H. G. N. - DUVENIG
(b) Address: Clinton Mo

19. (a) 10-13-48 (b) R. R. Kennedy
(Date received local registrar) (Registrar's signature) 115 C.

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: Ed. C. Peeler M. D. or other _____
Address: Clinton Mo Date signed: 10/13/48

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

MAR 9 1958

RECEIVED
District Health Officer No. 7,
District File Number 9-48-1215-
Date Filed 10-18-48

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.....

Robert L. Dunning

Registered Apprentice No. 3682

working under my personal supervision.

Signed.....

J. P. Housley

Licensed Embalmer No. 3682

P. O. Address Calhoun, 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.