

FILED MAY 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18463

BIRTH NO. _____ REG. DIST. NO. 373 PRIMARY REG. DIST. NO. 6269 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY Webster		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Webster	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Ozark township		c. LENGTH OF STAY (In this place) 4 years	
d. FULL NAME OF HOSPITAL OR INSTITUTION x /		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural	
		d. STREET ADDRESS (If rural, give location) Ozark township	

3. NAME OF DECEASED (Type or Print) Marie	a. (First)	b. (Middle)	c. (Last) Mowery	4. DATE OF DEATH (Month) (Day) (Year) May-17-1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH March 26-1873	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Days x	IF UNDER 10 HRS. Hours x	IF UNDER 1 MIN. Min. x
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Monticella, Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Collins	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE W.W. Mowery
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. x	17. INFORMANT'S SIGNATURE OR NAME H.V. Mowery-Niangwa, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis			1 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Mesenteric Thrombosis			2 day
	DUE TO (c) Hypertensive Heart disease		4 1/2	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		6 years		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3-14-49, 19__, to 5-17-49, 19__, that I last saw the deceased alive on 5-15-49, 19__, and that death occurred at 10:30A.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert A. Beas M.D.	23b. ADDRESS Marshfield Mo.	23c. DATE SIGNED 5-20-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-19-1949	24c. NAME OF CEMETERY OR CREMATORY Marshfield	24d. LOCATION (City, town, or county) (State) Marshfield, Missouri
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DATE REC'D BY LOCAL REG. 5-21/49	REGISTRAR'S SIGNATURE Francis 392	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rev. Rainey-Marshfield, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

113

RECEIVED

District Health Officer No. 6,

District File Number 549-592

Date Filed 5-23-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____
Student Embalmer

Signed Rex Rainey

Licensed Embalmer No. 3312

P. O. Address Marshfield, 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.