

FILED DEC 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36264

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 27 PRIMARY REG. DIST. NO. 3005 Registrar's No. 95

| | | | |
|---|------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Bates</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) Rosser <u>Butler</u> (township) <u>1</u> | | c. CITY (If outside corporate limits, write RURAL and give township) Town <u>Foster</u> | |
| c. LENGTH OF STAY (in this place) <u>2 MO.</u> | | d. STREET ADDRESS (If rural, give location) <u>RFD</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Butler Memorial Hospital</u> | | | |
| 3. NAME OF DECEASED a. (First) <u>Ollie</u> b. (Middle) <u>Myrtle</u> c. (Last) <u>Gowin</u> | | | 4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>2</u> (Year) <u>49</u> |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Aug. 31, 1893</u> |
| 9. AGE (In years last birthday) <u>56</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 11. BIRTHPLACE (State or foreign country) <u>Bates County, Mo</u> |
| 10a. USUAL OCCUPATION | | 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13a. FATHER'S NAME <u>Alonzo Bright</u> | | 13b. MOTHER'S MAIDEN NAME <u>Rachel Wilson</u> | 14. NAME OF HUSBAND OR WIFE <u>Dewey Gowin</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Dewey Gowin</u> ADDRESS <u>Foster, Mo.</u> |

| | | | |
|---|--|-------------|----------------------------------|
| 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) <u>Cerebratory collapse</u> | | <u>2 hours</u> |
| | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of Liver</u> | | <u>6 months</u> |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | <u>155X</u> | |

| | | |
|---|--|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 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) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Aug. 8th, 1949, to Dec. 2nd, 1949, that I last saw the deceased alive on Dec. 2nd, 1949, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

| | | | |
|--|--|---|---|
| 23a. SIGNATURE <u>L. D. Lathrop, M.D.</u> | (Degree or title) | 23b. ADDRESS <u>Butler, Mo</u> | 23c. DATE SIGNED <u>12-3-49</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Dec. 4, 1949</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Foster Missouri</u> |
| DATE REC'D BY LOCAL REG. <u>Dec 4 1949</u> | REGISTRAR'S SIGNATURE <u>Harold Perry</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Underwood</u> | ADDRESS <u>Butler, Mo</u> |

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

RECEIVED

District Health Officer No. 7;

District File Number 11-49-1448

Date Filed 12-12-49

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.

Student _____
Student Embalmer

Signed Louise T. Hill

Licensed Embalmer No. 4743

P. O. Address Butler, 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.