

FILED JAN 30 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 995

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 142 PRIMARY REG. DIST. NO. 5333 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <b>Howell</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Howell</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Mountain View, Mo</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Mountain View, Mo</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>R Chapel Twp</b>		d. STREET ADDRESS (If rural, give location) <b>Rural Chapel Twp</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Samuel</b>	b. (Middle) <b>Oliver</b>	c. (Last) <b>Carrow</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Jan 19-50</b>
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>March 20-1871</b>	9. AGE (in years last birthday) <b>78</b>	IF UNDER 1 YEAR <b>9</b> Days	IF UNDER 24 HRS. <b>22</b> Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wayland, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Oliver Carrow</b>	13b. MOTHER'S MAIDEN NAME <b>Rachel McCune</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>517-16-0167</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Birth Certificate</b>	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) <b>Coronary Artery Disease</b>		
	ANTECEDENT CAUSES <b>Myocarditis</b>		
	DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>4301</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <b>Robert W. D. Crowe</b>	(Degree or title)	23b. ADDRESS <b>Howell Co West Plains, Mo</b>	23c. DATE SIGNED <b>13-1-50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Jan 15-50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mtn View, Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Mtn View Mo</b>
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DATE REC'D BY LOCAL REG. <b>1-16-50</b>	REGISTRAR'S SIGNATURE <b>Laura Mitchell</b>	126	25. FUNERAL DIRECTOR'S SIGNATURE <b>Duncan F, Home</b>	ADDRESS <b>Mtn View, Mo</b>
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

0460

RECEIVED 1/23/50  
District Health Officer No. 5,  
District File Number 15069  
Date Filed 1/26/50

FORM 10730

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.....

working under my personal supervision.

Signed.....  
Student Embalmer

Signed *John J. Leeman*  
Student Embalmer No.....  
Licensed Embalmer No. 2576  
P. O. Address *M. Street 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.