

FILED MAY 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12606**

No. 300
10.48

396
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **418**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE mo. b. COUNTY webster	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) marshfield 1121	
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital		d. STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED (Type or Print) a. (First) Daisy b. (Middle) Jane c. (Last) McGowan		4. DATE OF DEATH (Month) (Day) (Year) April 30 1950	
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 25, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Brown Co, Ind. /
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Durham Bagwell	
13b. MOTHER'S MAIDEN NAME Mollie Sherrill		14. NAME OF HUSBAND OR WIFE David L. McGowan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Merrill M. McGowan		ADDRESS Cothage Mo.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial short drive + failure *Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congenituous cholecytitis + cholelithiasis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arthritis Prolapsus of uterus	
INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years 5x4x 10 years 20 years		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION 4/28/50		19b. MAJOR FINDINGS OF OPERATION Congenituous cholecytitis + cholelithiasis	
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) (Min.)	
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 4/24/1950 , to 4/30/1950 , that I last saw the deceased alive on 4/29/1950 , and that death occurred at 4:20 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Airword G. Hall (Degree or title)		23b. ADDRESS Springfield, Mo.	
23c. DATE SIGNED 5/4/50		24a. BURIAL, CREMATION, REMOVAL (Specify) burial	
24b. DATE 4-30-50		24c. NAME OF CEMETERY OR CREMATORY marshfield	
24d. LOCATION (City, town, or county) (State) marshfield, mo.		DATE REC'D BY LOCAL REG. 5-6-50	
REGISTRAR'S SIGNATURE W. J. Handley		25. FUNERAL DIRECTOR'S SIGNATURE Denver Roller	
ADDRESS marshfield, mo.		ADDRESS marshfield, mo.	

(Licensed Embalmer's Statement on Reverse Side)

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 Denver Roller

Licensed Embalmer No. 4006

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.