

FILED MAR 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8115
247

BIRTH NO. 13009-57 REG. DIST. NO. 1-40 PRIMARY REG. DIST. NO. 2000 Registrar's No. 247

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Howell	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Mtn. View, Rural	
c. LENGTH OF STAY (In this place) 2 hrs.		d. STREET ADDRESS (If rural, give location) Route 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION ZARK OSTEOPATHIC HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) (Unnamed) b. (Middle) c. (Last) Rowlett	4. DATE OF DEATH (Month) (Day) (Year) 3 19 51
--	---

5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 3-18-51	9. AGE (In years last birthday) 1	# UNDER 1 YEAR Months 1	# UNDER 1 MRS. Hours 1
--------------------	-------------------------------	---	---------------------------------	--	--------------------------------	-------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mtn. View, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
---	-----------------------------------	--	---

13a. FATHER'S NAME Jake Rowlett	13b. MOTHER'S MAIDEN NAME Louise Grove	14. NAME OF HUSBAND OR WIFE
--	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mr. Jake Rowlett	ADDRESS Mtn. View, 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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Post Surgical Shock		INTERVAL BETWEEN ONSET AND DEATH 7561
	ANTECEDENT CAUSES DUE TO (a) Reconstruction of Anus.		
	DUE TO (b) Congenital Closure of Anus.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 3-19-51	19b. MAJOR FINDINGS OF OPERATION Congenital closure of anus.	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 3-19-1951 to 3-19-1951, that I last saw the deceased alive on 3-19-1951, and that death occurred at 7:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE <i>William D. Methyl</i> (Degree or title)	23b. ADDRESS Springfield Mo	23c. DATE SIGNED 3-19-51
---	------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 3-20-1951	24c. NAME OF CEMETERY OR CREMATORY Center Hill Cem	24d. LOCATION (City, town, or county) (State) DUNCAN FUNERAL HOME
---	----------------------------	---	--

DATE REC'D BY LOCAL REG. 3-21-51	REGISTRAR'S SIGNATURE <i>W.E. Handley</i>	25. FUNERAL DIRECTOR'S SIGNATURE DUNCAN FUNERAL HOME	ADDRESS MOUNTAIN VIEW, MO.
---	---	---	-----------------------------------

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

96
0

00103

394504

STATE OF MASSACHUSETTS

John A. [Signature]

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.

Student Embalmer No. _____

Student :
Student Embalmer

Signed *John A. [Signature]*
Licensed Embalmer No. *2516*
P. O. Address *Northwood Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.