

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10-48

FILED MAY 25 1953

BIRTH NO.		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>591</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> <u>0117</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> <u>0117</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>50 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> <u>0</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1618 So. 9th St.</u>				d. STREET ADDRESS (If rural, give location) <u>1618 So. 9th St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WALTER</u>		b. (Middle) <u>B.</u>		c. (Last) <u>COWGILL</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>15</u> (Year) <u>1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov. 21, 1874</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Mins. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Hosp. #2</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Streator, Illinois /</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Joseph B. Cowgill</u>			13b. MOTHER'S MAIDEN NAME <u>Eunice E. Hagaman</u>		14. NAME OF HUSBAND OR WIFE <u>Nora Cowgill</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>491-10-3247</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Nora Cowgill, St. Joseph, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Decompensation</u>					
		ANTECEDENT CAUSES					
		DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Asthma</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>241X</u>					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 <u>2</u> , 19 <u>40</u> , to <u>May 15</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>May 15</u> , 19 <u>53</u> , and that death occurred at <u>7:40A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>W. E. Hartsock, M.D.</u>			23b. ADDRESS <u>3132 St. Joseph Ave., City</u>		23c. DATE SIGNED <u>5-18-53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>May 18, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>May 21, 1953</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. Meiladroffer, Salem, Mo.</u> <u>H. J. Buehly, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

