

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 3127 Registrar's No. 123

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Webb City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Webb City	
c. LENGTH OF STAY (in this place) 19 Yrs		d. STREET ADDRESS (If rural, give location) 1018 W. Daugherty	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1018 W. Daugherty			

3. NAME OF DECEASED (Type or Print)	a. (First) Thaddeus	b. (Middle) C	c. (Last) Cowen	4. DATE OF DEATH (Month) (Day) (Year) Aug. 21, 1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 16, 1873	9. AGE (in years last birthday) 80	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 5	Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Smithport, Penn.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME I.H. Cowen	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Estella Cowen
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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) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Estella Cowen, 1018 W. Daugherty St. Webb City, Mo.
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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) Carcinoma of prostate		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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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?
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22. I hereby certify that I attended the deceased from Nov. 25, 1949, to Aug. 21, 1953, that I last saw the deceased alive on Aug. 13, 1953, and that death occurred at 9:25 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature] M.D.	23b. ADDRESS Webb City, Mo.	23c. DATE SIGNED 8-24-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-24-53	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	24d. LOCATION (City, town, or county) (State) Webb City, Mo.
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DATE REC'D BY LOCAL REG. 8-24-53	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Johnston-Arnce-Simpson, Webb City, Mo. Mortuary
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(Licensed Embalmer's Statement on Reverse Side)

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

0492

0492

AUG 31 1953

RECEIVED

County Health Office

712  
AUG 31 1953

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 Jack C. Simpson

Licensed Embalmer No. 4647

P. O. Address Webb City, 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.