

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31224

State File No.

FILED OCT 7 - 1953

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>55</u> | | PRIMARY REG. DIST. NO. <u>3011</u> | | Registrar's No. <u>98</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If in institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN <u>Carrollton</u> | | c. LENGTH OF STAY (In this place) | | c. CITY OR TOWN <u>Carrollton</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>415 N. Hoxie</u> | | | | e. STREET ADDRESS (If rural, give location) <u>415 N. Hoxie - 017/0</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>BESSIE FRANCES COWICK</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 23 1953</u> | | | | |
| 5. SEX <u>Fe.</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>Aug. 2, 1879</u> | |
| 9. AGE (In years, last birthday) <u>74</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>Indiana</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Unknown</u> | | 13b. MOTHER'S MAIDEN NAME | | 14. NAME OF HUSBAND OR WIFE <u>Frank Cowick</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Frank Cowick, Wakeanda Mo</u> | | | |
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION | | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myo cardiac Insufficiency</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | | | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary & Arteriosclerosis</u> | | | | 6 mos. | | | |
| 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 | | 1561 | | 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>June 15, 1953</u> to <u>Sept. 23, 1953</u> , that I last saw the deceased alive on <u>Sept. 23, 1953</u> and that death occurred at <u>10:30 a.m.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Ernest R. Smith M.D.</u> | | | | 23b. ADDRESS <u>10th. 9th St. Carrollton, Mo</u> | | 23c. DATE SIGNED <u>9/26/53</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>9-25-53</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Adrian Cem</u> | | 24d. LOCATION (City, town, or county) (State) <u>Carroll Co Mo.</u> | |
| DATE REC'D BY LOCAL REG. <u>9/29/53</u> | | REGISTRAR'S SIGNATURE <u>Mr. Herbert Calvert</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Standley & Gibson, Carrollton, Mo.</u> | | | |

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

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.....
Signature of Student Embalmer

Signed *Ben W. Gibson*

Licensed Embalmer No. *290*

P. O. Address *Carroll*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.