

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3893**
Registrar's No. **38**

FILED MAR 8 1954

BIRTH NO. _____ REG. DIST. NO. **10** PRIMARY REG. DIST. NO. **5037**

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

1. PLACE OF DEATH a. COUNTY Audrain		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Audrain	
b. CITY OR TOWN RFD-Salt River		c. CITY OR TOWN Molino	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) RFD Molino, Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION RFD Molino, Missouri		0048	
3. NAME OF DECEASED (Type or Print) a. (First) Chester b. (Middle) L. c. (Last) Dowell			4. DATE OF DEATH (Month) (Day) (Year) March 2, 1954
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 12, 1866
9. AGE (In years last birthday) 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (City and State or Foreign Country) Audrain Co., Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME George A. Dowell	
13b. MOTHER'S MAIDEN NAME Nancy Anna Rouse		14. NAME OF HUSBAND OR WIFE Anna L. Dowell	
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. no	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Homer Baker, Paris, Mo,		ADDRESS	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
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"/>
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) m.	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 **10-31-1950**, to **3-2-1954**, that I last saw the deceased alive on **2-5-1954**, and that death occurred at **2:30 A m.**, from the causes and on the date stated above.

23a. SIGNATURE J. A. Barnett M.D.	(Degree or title)	23b. ADDRESS Paris, Mo.	23c. DATE SIGNED 3-4-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-4-54	24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	24d. LOCATION (City, town, or county) (State) Mexico, Missouri

DATE REC'D BY LOCAL REG. Mar-4-1954	REGISTRAR'S SIGNATURE Blanche Kelly	25. FUNERAL DIRECTOR'S SIGNATURE ARNOLD FUNERAL Home	ADDRESS Mexico, Mo.
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MAR 12 1957

JUL 31 1957

FEB 17 1955

AUG 2 1956

SEP 5 1957

1957

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 *Richard Y. McDonald*

Licensed Embalmer No. *482*

P. O. Address *Merica, Va.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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