

THE DIVISION OF HEALTH OF MISSOURI
 FILED AUG 5 - 1955 STANDARD CERTIFICATE OF DEATH

22815

State File No.

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 139

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY OR TOWN <u>Chillicothe</u>	c. LENGTH OF STAY (in this place) <u>3 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe / Rural 2590</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Chillicothe Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>5 mile East</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Sarah</u> b. (Middle) <u>Elizabeth</u> c. (Last) <u>Dowell</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>7-27-1955</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-11-1869</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Thomas De Witt</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Johnston</u>	14. NAME OF HUSBAND OR WIFE <u>George W. Dowell</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Van Neff</u> ADDRESS <u>Chillicothe Mo</u>
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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, asthma, 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) <u>Pneumonia, Terminal, Bronchial</u>		<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>Cardiac Insufficiency</u> DUE TO (c) <u>Mitral Stenosis</u>		<u>1 yr</u> <u>15 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>410X</u>			

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)	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 Jan 1, 1951 to July 27, 1955, that I last saw the deceased alive on July 27, 1955, and that death occurred at 105 P. M. from the causes and on the date stated above.

23a. SIGNATURE <u>Joseph A. Conrad M.D.</u> (Degree or title)	23b. ADDRESS <u>Chillicothe Mo</u>	23c. DATE SIGNED <u>July 27-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>7-27-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Christian Union Home</u>	24d. LOCATION (City, town, or county) (State) <u>Gilman City Mo</u>
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DATE REC'D BY LOCAL REG. <u>7-27-55</u>	REGISTRAR'S SIGNATURE <u>Francis B Neel</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>MsKear</u> ADDRESS <u>Bethany Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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.

Signed _____

MBA

Signed _____
Student Embalmer

Licensed Embalmer No. *3899*

P. O. Address *Bethany 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.