FILED FEB 11 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1990

STATE FILE NUMBER

Registration District No. 207 Primary Registration District No. 5758 Registrar's No. 5

1. PLACE OF DEATH
a. COUNTY Maries
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural North Miller — Inside Limits Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Maries
c. CITY OR TOWN Rural North Miller — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First Clara Middle Ann Last Rowden
4. DATE OF DEATH: Month 2 Day 4 Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/16/1881
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): Maries County, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John N. Williams
14. MOTHER'S MAIDEN NAME: Sarah Cooper
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): X
16. SOCIAL SECURITY NO.: X
17. INFORMANT: Mr. Floyd Rowden, Dixon, Missouri — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary oedema — INTERVAL BETWEEN ONSET AND DEATH: 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Acute congestive heart failure — 1 week
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Diabetes mellitus with diabetic gangrene of foot. 260X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from Nov 1 1956, to Feb 3, 1957 and last saw her alive on Feb 3, 1957
Death occurred at 1:35 P. M. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Conley Gates (Degree or title) D.O.
22b. ADDRESS Dixon, Mo.
22c. DATE SIGNED 2-5-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2/6/1957
23c. NAME OF CEMETERY OR CREMATORY Dodds Cemetery
23d. LOCATION (City, town, or county) (State) Maries County, Missouri
24. FUNERAL DIRECTOR Fred H. Gilbert — ADDRESS Dixon, Missouri
25. DATE RECD. BY LOCAL REG. 2-6-57
26. REGISTRAR'S SIGNATURE Pauline Howard

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed. Maurice E. Schierhu

Licensed Embalmer No. 450

P. O. Address Dixon, Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.