

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20896

STATE FILE NUMBER

FILED JUL 1 1957

Registration District No. 141 Primary Registration District No. 5550 Registrar's No. 92

300
-57

1. PLACE OF DEATH a. COUNTY <u>Haskell</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Haskell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Hoceaus</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hoceaus</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb	d. STREET ADDRESS <u>0460</u> (If outside, give location) <u>0</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Amanda Jane</u> Middle <u>Rowning</u> Last <u>Rowning</u>			4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wht</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1873</u>		9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR: Months <u>11</u> Days <u>15</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Haskell Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Thomas B. Nicholas</u>		13b. MOTHER'S MAIDEN NAME <u>Susanna Black</u>		14. NAME OF HUSBAND OR WIFE <u>H. A. Rowning</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)	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Beulah Beput Hoceaus Mo.</u> Address	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO (b) <u>cerebral thrombosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>332X</u>		
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20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a.m. <u></u> p.m. <u></u>			
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <u>4/3/57</u> to <u>6/16/57</u> and last saw ^{her} alive on <u>6/16/57</u> Death occurred at <u>2:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.				
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22a. SIGNATURE <u>M. L. Fowler</u> (Degree or title)	22b. ADDRESS <u>MD West Plains Mo</u>	22c. DATE SIGNED <u>6/21/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>6-18-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Way Union Cemetery Hoceaus Mo.</u>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <u>Ashester Neet Hains Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-25-57</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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(License Embalmer's Statement on Reverse Side)
Fowler

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *L. J. Drago*

Licensed Embalmer No. *4547*

P. O. Address

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.