Health, Welfare Public Service

300 -57

FILED FEB 14 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1087

STATE FILE NUMBER

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 7

1. PLACE OF DEATH
a. COUNTY Howard
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 309 S. Church — Length of stay in 1b 42 yr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Howard
c. CITY OR TOWN Fayette — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 309 S. Church — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First CORA Middle REAN Last ROWDEN

4. DATE OF DEATH Month Jan. Day 19 Year 1958

5. SEX Female 3

6. COLOR OR RACE Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH Sept. 23-1889

9. AGE (In years last birthday) 68 — 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) housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Howard County

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Rufen Tolson

13b. MOTHER'S MAIDEN NAME Genora Boone

14. NAME OF HUSBAND OR WIFE Robert Rowden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Ruth Rowden Address Fayette Mo.

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) cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH 8 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) undetermined cause
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE ☐ natural

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) none

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 Aug, 1957, to Jan 58 and last saw her alive on Jan 19, 1958
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wm J. Shaw, Jr. M.D.

22b. ADDRESS Fee Hospital, Fayette Mo.

22c. DATE SIGNED 1-22-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 1/22/58

23c. NAME OF CEMETERY OR CREMATORY Fayette

23d. LOCATION (City, town, or county) Fayette (State) Mo.

24. FUNERAL DIRECTOR Mrs Stuart Parker, ADDRESS Columbia Mo.

25. DATE RECD. BY LOCAL REG. 1-22-58

26. REGISTRAR'S SIGNATURE Mary K. Shell

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 10. No symptoms ... 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 George H. Green

Licensed Embalmer No. 4220

P. O. Address Marshall, Mo.

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.