

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026009
STATE FILE NUMBER

FILED JUL 16 1958 Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 131

1. PLACE OF DEATH a. COUNTY Jasper			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Wade		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Greenfield Mo 0290		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Parker Memorial		Length of stay in 1b 6mo	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Given Middle M Last Nowling			4. DATE OF DEATH Month Day Year July 4 1958		
5. SEX m 2	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 22, 1874	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months 6 Days 12 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (City and state or country) Dade Co	12. CITIZEN OF WHAT COUNTRY? usa	
13a. FATHER'S NAME Anison Nowling		13b. MOTHER'S MAIDEN NAME Jane Nowling		14. NAME OF HUSBAND OR WIFE Sissie Nowling	
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. none	17. INFORMANT Address Duelah Chitwood 864 1/2 3rd St Carthage Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) 4222					
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"/> 2					
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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	
21. I attended the deceased from Nov. 25 - 1957 to 7-4-58 and last saw her alive on May 29 - 58 Death occurred at 7:30p m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) H. G. Byrd M.D.			22b. ADDRESS 612 S. Main St. Carthage Mo		22c. DATE SIGNED 7/7/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 8, 1958	23c. NAME OF CEMETERY OR CREMATORY Greenfield		23d. LOCATION (City, town, or county) (State) Greenfield Mo.
24. FUNERAL DIRECTOR W. R. Allison		ADDRESS Greenfield Mo.		25. DATE RECD. BY LOCAL REG. 7-7-58	26. REGISTRAR'S SIGNATURE Ely Clinton

(Licensed Embalmer's Statement on Reverse Side)

Health & Welfare Public Health Service 430
S. 300
1-57
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *W. R. Allison*

Licensed Embalmer No. *4404*

P. O. Address *Greenville*

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.