

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035270

STATE FILE NUMBER

FILED OCT 14 1958 Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 187

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Vernon</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Nevada</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Nevada</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>		Length of stay in 1b <b>45 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>814 No. Lynn</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Franklin</b> Last <b>Rowland</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>3</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/11/1874</b>	9. AGE (In years last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Johnstown, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Daniel B. Rowland</b>		13b. MOTHER'S MAIDEN NAME <b>Anne Brañowland</b>		14. NAME OF HUSBAND OR WIFE <b>Cora D. Rowland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> <input type="checkbox"/> <b>X</b> <input checked="" type="checkbox"/> <b>X</b> <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <b>491 05 9022</b>	17. INFORMANT Address <b>Mrs. R. Moore Nevada, Missouri</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral metastatic osteosarcoma both lungs</b> Interval between ONSET AND DEATH <b>2 mos.</b> DUE TO (b) <b>Primary osteosarcoma of the first metacarpal</b> Interval between ONSET AND DEATH <b>4 mos.</b> DUE TO (c) <b>1965</b>					
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"/> <b>2</b>					
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 <b>Aug. 2, 1958</b> to <b>Oct. 3, 1958</b> and last saw <del>the</del> him alive on <b>Oct. 2, 1958</b> Death occurred at <b>Nevada, Missouri 12:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>R. B. Wray, M.D.</i> (Degree or title) <b>R. B. Wray, M.D.</b>			22b. ADDRESS <b>Moore Bldg., Nevada, Mo.</b>		22c. DATE SIGNED <b>10/3/1958</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4 Oct.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Deerwood Cemetery</b>		23d. LOCATION (City, town, or country) (State) <b>Nevada, Missouri.</b>	
24. FUNERAL DIRECTOR <b>Richard L. Shorten</b>		ADDRESS <b>Nevada, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-7-1958</b>	26. REGISTRAR'S SIGNATURE <i>Uma E. Sherry</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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  .....

Licensed Embalmer No. 4532  
P. O. Address Nevada .....

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.