Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002123
STATE FILE NUMBER

FILED FEB 9 1959 Registration District No. 224 Primary Registration District No. 3046 Registrar's No. 19

1. PLACE OF DEATH
a. COUNTY: Moniteau
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: California, Mo Walker — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Latham Hospital — Length of stay in Ib: 6 Hrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Moniteau
c. CITY OR TOWN: California, Mo — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): Noas — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Garland Middle: Last: Fowler-JR.

4. DATE OF DEATH: Month Feb Day 4 Year 1959

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Feb 4 1959

9. AGE (In years last birthday): IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours 6 Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): California, Mo

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

13a. FATHER'S NAME: Garland Fowler

13b. MOTHER'S MAIDEN NAME: Lovella Ross

14. NAME OF HUSBAND OR WIFE: None

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

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Garland Fowler Address: California 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): Patent interventricular septum — INTERVAL BETWEEN ONSET AND DEATH: 6 hours.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Congenital defect.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 7542

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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 Feb 4, 1959, to Feb 4, 1959 and last saw ~~her~~ him alive on Feb 4, 1959
Death occurred at 7/10 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Kenyon Latham M.D.

22b. ADDRESS: California, Mo

22c. DATE SIGNED: 2-5-59

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

23b. DATE: 2/5/59

23c. NAME OF CEMETERY OR CREMATORY: City Cemetery

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

24. FUNERAL DIRECTOR ADDRESS: Frank Boulin California Mo

25. DATE RECD. BY LOCAL REG.: 2-7-59

26. REGISTRAR'S SIGNATURE: Helen L Popejoy

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.....

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.