Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004261
STATE FILE NUMBER

FILED FEB 3 1959

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 17

1. PLACE OF DEATH
a. COUNTY Vernon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital #3 — Length of stay in 1b 3 yrs 5 mo 27 days
d. STREET ADDRESS (If outside, give location) 1401 N. Phelps — Reside on Farm Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Greene
c. CITY OR TOWN Springfield — Inside Limits Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First TOM Middle C. Last ROWDEN

4. DATE OF DEATH: Month 1 Day 23 Year 1959

5. SEX M.
6. COLOR OR RACE W.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8/1/1883
9. AGE (In years last birthday) 75 — 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) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Carpenter
11. BIRTHPLACE (City and state or country) Greene Co. Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Albert T. Rowden
13b. MOTHER'S MAIDEN NAME Mary V. Carnes
14. NAME OF HUSBAND OR WIFE single

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 State Hospital records — Address

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) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: one week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — yrs.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 12/31/56, to 1/23/59 and last saw him alive on 1/23/59
Death occurred at 9:05 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE George Esker M.D. (Degree or title)
22b. ADDRESS State Hospital No 3.
22c. DATE SIGNED 1/23/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 1/24/59
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery
23d. LOCATION (City, town, or county) (State) Springfield, Missouri

24. FUNERAL DIRECTOR Rainye's Chapel — ADDRESS Springfield, Mo.
25. DATE RECD. BY LOCAL REG. 1-28-1959
26. REGISTRAR'S SIGNATURE Annal E. Perry

(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 Percy F. Milster

Licensed Embalmer No. 4805

P. O. Address Nevada, 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.