

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009216
STATE FILE NUMBER

FILED APR 15 1959

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 35

300
1-57

1. PLACE OF DEATH a. COUNTY Howell			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howell		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN West Plains		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Pomona <u>0460</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION W.P. Memorial Hosp.		Length of stay in 1b 14hrs	d. STREET ADDRESS Rural R-2 (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CURTIS Middle RAY Last BROWER			4. DATE OF DEATH Month Mar Day 11 Year 1959		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Child <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1954	9. AGE (In years last birthday) 4	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) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) West Plains, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Lester Brower		13b. MOTHER'S MAIDEN NAME Lois Miller		14. NAME OF HUSBAND OR WIFE	
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 Lester Brower, Fair Grove, 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) Generalized peritonitis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Ruptured appendix and DUE TO (c) appendiceal abscess PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Paralytic ileus					INTERVAL BETWEEN ONSET AND DEATH 4 days 5 days 5 days
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 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 <u>3/10/59</u> to <u>3/11/59</u> and last saw ^{him} alive on <u>3/11/59</u> Death occurred at <u>11:30</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) M. L. Fowler M.D.			22b. ADDRESS West Plains Mo		22c. DATE SIGNED 3/27/59
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Mar. 14, 1959	23c. NAME OF CEMETERY OR CREMATORY Chapel Hill Cem.		23d. LOCATION (City, town, or county) (State) Howell County, Mo.
24. FUNERAL DIRECTOR Island Carter		ADDRESS CARTER FUNERAL HOME WEST PLAINS, MO.	25. DATE RECD. BY LOCAL REG. 4-8-59	26. REGISTRAR'S SIGNATURE Beatrice Cook	

(Licensed Embalmer's Statement on Reverse Side)

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 Richard Carter

Licensed Embalmer No. 4516
CARTER FUNERAL HOME
WEST PLAINS, MO.
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.