pt. Health,
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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59--020223
STATE FILE NUMBER

FILED MAY 18 1959 Registration District No. 362 Primary Registration District No. 4531 Registrar's No. 26

1. PLACE OF DEATH
a. COUNTY: WARREN
b. CITY OR TOWN: WARRENTON — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: — Length of stay in 1b: 17 years
d. STREET ADDRESS (If outside, give location): 1090 — Reside on Farm: Yes [ ] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO b. COUNTY: WARREN
c. CITY OR TOWN: WARRENTON — Inside Limits: Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First: LONNIE Middle: Last: TROWER

4. DATE OF DEATH: Month: May Day: 14 Year: 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Aug 6 1879
9. AGE (In years last birthday): 79 — 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): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Olney Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: John Trower
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: Lelia Trower

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Loyd Trower Address: Warrenton 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) Adenocarcinoma of Bladder — INTERVAL BETWEEN ONSET AND DEATH: 10 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Pulmonary Emphysema, arteriosclerotic heart disease 1810
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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

ITEM 25 CORRECTED BY AFFIDAVIT OF Registrar 5-18-59

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 ~~5-14-59~~ 4-22-50, to 5-14-59 and last saw ~~her~~ him alive on 5-13-59
Death occurred at 5:15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: A. N. MacRae (Degree or title) M.D.
22b. ADDRESS: Warrenton, Mo.
22c. DATE SIGNED: 5-16-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 5-16-59
23c. NAME OF CEMETERY OR CREMATORY: Oak Grove
23d. LOCATION (City, town, or county): Jonesburg (State): Mo

24. FUNERAL DIRECTOR: Carl Harding ADDRESS: Jonesburg Mo
25. DATE RECD. BY LOCAL REG.: May 16, 1959
26. REGISTRAR'S SIGNATURE: Floyd Logan

(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

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 Paul A Harding

Licensed Embalmer No. 4115

P. O. Address Jonesburg 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.