

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022007

STATE FILE NUMBER

FILED JUL 13 1959 Registration District No. 169 Primary Registration District No. \_\_\_\_\_ Registrar's No. 36

1. PLACE OF DEATH a. COUNTY <b>Knox</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Knox</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rutledge</b>		c. CITY OR TOWN <b>Rutledge</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Residence</b>		d. STREET ADDRESS (If outside, give location) <b>052 S</b>	
Length of stay in lb <b>life</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>WILFORD</b> Last <b>FWLER</b>			4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1959</b>		
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5. SEX <b>M</b>	6. COLOR OR RACE <b>Q</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 28, 1878</b>	9. AGE (In years) <b>80</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Sandhill, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Walter Fowler</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Cunningham</b>	14. NAME OF HUSBAND OR WIFE <b>Ona Buford</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>486-42-1630</b>	17. INFORMANT <b>Mrs. George Fowler</b>	Address <b>Rutledge, Mo</b>
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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>A cute myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>arteriosclerotic heart disease</b>	<b>2 years</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) <b>4200</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <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 <b>Quincy Clinic - Quincy, Illinois</b>	COUNTY _____ STATE _____
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21. I attended the deceased from <b>10-19-58</b> , to <b>7-6-59</b> and last saw <del>him</del> <b>her</b> alive on <b>7-1-59</b> Death occurred at <b>8:00 A. M. CST</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Robert C. Murphy, MD</b>	22b. ADDRESS <b>Quincy Clinic - Quincy, Illinois</b>	22c. DATE SIGNED <b>7-7-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>8 July 59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Grove Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>S. E. of Rutledge, Mo</b>
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24. FUNERAL DIRECTOR <b>AG Griner</b> <b>Hudson Funeral Home</b>	ADDRESS <b>Edina, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>July 7-59</b>	26. REGISTRAR'S SIGNATURE <b>Dale S. Hunt</b>
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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.

S. 300  
1-57

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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 *AG Rimer* .....

Licensed Embalmer No. *5041* .....

P. O. Address *Edina, Mn* .....

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.