

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025590

FILED VS AUG 11 1959 6

Registration District No. 77 Primary Registration District No. 5568 Registrar's No. 348 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Pulaski	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN (Blue) 7		c. CITY OR TOWN Ft Leonard Wood	
Length of stay in 1b Unk		Inside Limits <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1 Mi So on off 77 off River rd		d. STREET ADDRESS (If outside, give location) 1	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Donald Middle Warren Last Stowell			4. DATE OF DEATH Month 8 Day 4 Year 1959		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/7/33	9. AGE (last birthday) 26	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service man	10b. KIND OF BUSINESS OR INDUSTRY U S Army	11. BIRTHPLACE (City and state or country) Park Rapids, Minn	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME D. Warren Stowell	13b. MOTHER'S MAIDEN NAME Ethel Viola Stowell	14. NAME OF HUSBAND OR WIFE Elsa Stowell
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 7	16. SOCIAL SECURITY NO. 474-30-8981	17. INFORMANT Address Mortuary Officer, Ft. Leonard Wood
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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) Gunshot wound of head		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) head	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) apparently shot himself
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20c. TIME OF INJURY Hour 3:30 Month, Day, Year 8-4-59	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway	20f. CITY, TOWN, OR LOCATION COUNTY STATE Jackson Mo
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21. I attended the deceased from _____ to _____ and last saw him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Dr. C. K. ...	22b. ADDRESS 6027 ...	22c. DATE SIGNED 8-5-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/6/59	23c. NAME OF CEMETERY OR CREMATORY Sumpter Funeral Home	23d. LOCATION (City, town, or county) (State) Leavenworth, Kan
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24. FUNERAL DIRECTOR ADDRESS Shell Colonial Funeral Home K C. MO	25. DATE RECD. BY LOCAL REG. 8-6-59	26. REGISTRAR'S SIGNATURE James ...
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

2001 8 7 00W

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John P. Stuel

Licensed Embalmer No. 3625

P. O. Address K C M

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.