URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS JAN 27 1960 374

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 1

[redacted] STATE FILE NUMBER 59-047097

ENDED

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Worth
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Greene Township
Length of stay in 1b: Life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Worth
c. CITY OR TOWN Greene Township
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First Steven Middle Dell Last Rowen

4. DATE OF DEATH: Month Day Year: December 26, 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 10-10-1959

9. AGE (last birthday)

IF UNDER 1 YEAR: Months 1 Days 16
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (Infant)

10b. KIND OF BUSINESS OR INDUSTRY: (Infant)

11. BIRTHPLACE (City and state or country): Maryville, Missouri

12. CITIZEN OF WHAT COUNTRY: U. S.

13a. FATHER'S NAME: Henry Dell Rowen

13b. MOTHER'S MAIDEN NAME: Lois June Winemiller

14. NAME OF HUSBAND OR WIFE: Never Married

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: Lois June Rowen - Sheridan, Missouri

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): Aspiration into trachea of vomitus
INTERVAL BETWEEN ONSET AND DEATH: 0
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)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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.)

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 10-10-59, to 12-26-59 and last saw her/him alive on 12/24/59
Death occurred at 5am m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Frank B Matteson M D

22b. ADDRESS: Grant City, Mo

22c. DATE SIGNED: 11/26/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 12-27-1959

23c. NAME OF CEMETERY OR CREMATORY: Sheridan Cemetery

23d. LOCATION (City, town, or county) (State): Sheridan, Missouri

24. FUNERAL DIRECTOR ADDRESS: Bill Dunfee - Grant City, Mo

25. DATE RECD. BY LOCAL REG.: Jan 19-1960

26. REGISTRAR'S SIGNATURE: Bawdry Kibbe

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Bill A Dunlap

Licensed Embalmer No. 4908

P. O. Address Grant City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.