

**I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-000671**

**FILED VS JAN 15 1960 65**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 17 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Chariton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Chariton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Gunningham Township</b>		c. CITY OR TOWN <b>Sumner</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <b>lmi. South</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Lizzie Ann Cowen</b>			4. DATE OF DEATH <b>Jan. 10 1960</b>			
First Middle Last			Month Day Year			

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4 1869</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>6</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (City and state or country) <b>Sidney, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>

13a. FATHER'S NAME <b>Fredrick Auer</b>		13b. MOTHER'S MAIDEN NAME <b>Helena Hafner</b>		14. NAME OF HUSBAND OR WIFE <b>John A. Cowen (deceased)</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)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Viola Roupe</b> Address <b>Sumner, 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>Cerebral thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 d.o.A.</b>
DUE TO (b) <b>Generalized arteriosclerosis</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>Congestive heart failure</b>			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

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 _____ a.m. _____ p.m.	Month, Day, Year _____
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 COUNTY STATE

21. I attended the deceased from **Oct. 10 1950** to **1-10-60** and last saw her alive on **12-12-59**.  
Death occurred at **3:00 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>R.W. Bodman M.D.</b> (Degree or title)	22b. ADDRESS <b>Sumner Mo.</b>	22c. DATE SIGNED <b>1-11-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	23b. DATE <b>1-12-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakeside</b>	23d. LOCATION (City, town, or county) (State) <b>Sumner, Mo.</b>
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24. FUNERAL DIRECTOR <b>S. J. Shepard</b> ADDRESS <b>Menden Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Jan 12-1960</b>	26. REGISTRAR'S SIGNATURE <b>Lois Smith</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R. W. Bohusot M.D.

**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 S. L. Ripstein

Licensed Embalmer No. 3976

P. O. Address Mendon

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