

Health,  
& Welfare  
Public  
Service

FILED VS APR 4 1960

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

60-010093

STATE FILE NUMBER

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 184

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Butler</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Carter</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>VAN BUREN</b> <sup>01802</sup> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Poplar Bluff Hosp</b>		Length of stay in lb <b>4 11 days</b>	d. STREET ADDRESS (If outside, give location) <b>VAN BUREN</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>Cowen</b> Last <b>Rector</b>			4. DATE OF DEATH Month <b>3</b> Day <b>15</b> Year <b>1960</b>			
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"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-88</b>		9. AGE (In years last birthday) <b>71</b> IF UNDER 1 YEAR Months <b>11</b> Days <b>28</b> IF UNDER 24 HRS Hours <b></b> Min. <b></b>	

10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>VAN BUREN, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>GEORGE COWEN</b>	13b. MOTHER'S MAIDEN NAME <b>FRANCIS WHEELER</b>	14. NAME OF HUSBAND OR WIFE <b>John H. Rector (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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>W.T. Pullinger Jr.</b> Address <b>VAN BUREN, 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>Intentional strychnine poisoning</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>poisoning caused from Epilobus</b> DUE TO (c) <b>of skin about 30 inches above the level of the</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>5703</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 <b></b> Month, Day, Year <b></b> a.m. <b></b> p.m. <b></b>	
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20d. INJURY OCCURRED WHILE AT <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></b>	COUNTY <b></b>	STATE <b></b>
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21. I attended the deceased from **3-4-60** to **3-15-60** and last saw her alive on **3-14-60**  
Death occurred at **12:55 A.m** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Wm. H. Henschen M.D.</b> (Degree or title)	22b. ADDRESS <b>Poplar Bluff Mo</b>	22c. DATE SIGNED <b>3-23-60</b>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>3-17-1960</b>	23c. NAME OF CEMETERY OR CREMATOR* <b>VAN BUREN</b>	23d. LOCATION (City, town, or county) (State) <b>VAN BUREN, Mo.</b>
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24. FUNERAL DIRECTOR <b>Allen C. McSpadden</b> ADDRESS <b>VAN BUREN Mo</b>	25. DATE RECD. BY LOCAL REG. <b>3/25/60</b>	26. REGISTRAR'S SIGNATURE <b>Harold W. Miller M.</b>
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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

MEDICAL CERTIFICATION

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 ..... RONALD B. SLOAN ....., Student Embalmer No. 606 ....., working under my personal supervision.

Student ..... Ronald B. Sloan .....  
Signature of Student Embalmer

Signed ..... Allen C. McGee .....

Licensed Embalmer No. 4543 .....  
P. O. Address Van Buren, 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.