

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014665

FILED VS APR 26 1960 93

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 60-27 STATE FILE NUMBER

UNDED

1. PLACE OF DEATH a. COUNTY <b>Dade</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>GREENE</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>So. Greenfield</b>		Length of stay in 1b <b>1 WK.</b>	c. CITY OR TOWN <b>Walnut Grove</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 <b>Mitchell Rest Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2 1/2 miles South.</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Lou</b> Middle <b>Cowan</b> Last <b>Cowan</b>			4. DATE OF DEATH Month <b>April</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"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-1869</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF</b>	11. BIRTHPLACE (City and state or country) <b>Polk Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Thomas Gouty</b>		13b. MOTHER'S MAIDEN NAME <b>JANE Scroggins</b>		14. NAME OF HUSBAND OR WIFE <b>Andy Cowan, Deceased.</b>	
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>—</b>		17. INFORMANT Address <b>Claude Cowan, Walnut Grove, Mo.</b>	
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>Senility</b>					INTERVAL BETWEEN ONSET AND DEATH
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. <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.)	
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 <b>Feb. 12, 1959</b> , to <b>4-15-60</b> and last saw her <b>xxx</b> alive on <b>Mar. 23, 1960</b> Death occurred at <b>2:40 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Lester F. Matz, D.O.</b>			22b. ADDRESS <b>Ash Grove, Missouri</b>		22c. DATE SIGNED <b>4-18-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4-18-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENLAWN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>Walnut Grove, Missouri</b>	
24. FUNERAL DIRECTOR <b>Brian Daniel + Co. Walnut Grove, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4/22/1960</b>	26. REGISTRAR'S SIGNATURE <b>J. C. Canada</b>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAY 4 1960

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

*Ray R. Ireland*

Licensed Embalmer No. 5052

P. O. Address Valued Home

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.