

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Waverly</b>		Length of stay in 1b <b>60 years</b>		c. CITY OR TOWN <b>Waverly</b>		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>Kelling Clinic</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>X</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>Norine</b> Last <b>Sowers</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</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>5-17-1888</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and state or country) <b>Sarcouxie, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Randall T. Wood</b>			13b. MOTHER'S MAIDEN NAME <b>Isabelle Talbott</b>			14. NAME OF HUSBAND OR WIFE <b>Russell P. Sowers, Sr.</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>None</b>		17. INFORMANT <b>Mrs. Chris Jung, Higginsville, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>cerebral hemorrhage acute</b>							<b>25 minutes</b>	
DUE TO (b) <b>arteriosclerosis generalized</b>							<b>??</b>	
DUE TO (c) <b>hypertensive vascular disease</b>							<b>??</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) <b>pulmonary embolism following surgery for strangulated hernia 6/24/60.</b>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) <b>at intervals since 1939</b>		20f. CITY, TOWN, OR LOCATION <b>Waverly, Missouri</b>		COUNTY		STATE
21. I attended the deceased from <b>7/29/60</b> to <b>7/29/60</b> and last saw <b>him</b> alive on <b>7/29/60</b> Death occurred at <b>1:35 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Charles Kelling M.D.</b>				22b. ADDRESS <b>Waverly, Missouri</b>		22c. DATE SIGNED <b>7/30/60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-31-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Waverly Cemetery</b>		23d. LOCATION (City, town, or county) <b>Waverly, Missouri</b>		23e. STATE <b>Missouri</b>		
24. FUNERAL DIRECTOR <b>Gibson Funeral Home, Waverly, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>7. 31. 1960</b>		26. REGISTRAR'S SIGNATURE <b>Lutia Jordan</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF -

AUG 5 1960

**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

*James F. Gibson*

Licensed Embalmer No. 5076

P. O. Address Carrollton, 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.