MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

=61=000044
STATE FILE NUMBER

FILED VS JAN 24 1961 Registration District No. 4 Primary Registration District No. 4014 Registrar's No. 10

AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED	BY AFFIDAVIT OF

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Atchison
c. CITY OR TOWN: Tarkio — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): none — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Zuba Middle: Catherine Last: Bowen
4. DATE OF DEATH: Month 1 Day 12 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 7-28-1886
9. AGE (last birthday): 74 — IF UNDER 1 YEAR: Months 5 Days 14 — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): Illinois
12. CITIZEN OF WHAT COUNTRY: US
13a. FATHER'S NAME: Silas Hopping
13b. MOTHER'S MAIDEN NAME: Abigail Janes
14. NAME OF HUSBAND OR WIFE: William (Deceased)
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: Harrison Bowen Address: Tarkio, Mo.

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) Generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years.
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 1/7/61, to 1/12/61 and last saw her/him alive on
Death occurred at 3:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John M. Wanamaker, M.D.
22b. ADDRESS: Rock Port, Mo
22c. DATE SIGNED: 1/14/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1-14-1961
23c. NAME OF CEMETERY OR CREMATORY: Grange Hall Cem.
23d. LOCATION (City, town, or county) (State): Rock Port, Mo.
24. FUNERAL DIRECTOR ADDRESS: Bartholomew Mortuary, Rock Port.
25. DATE RECD. BY LOCAL REG.: Jan 20, 1961
26. REGISTRAR'S SIGNATURE: Marvin N. Schuler

(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 me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Gertz Barthalowe

Licensed Embalmer No. 3173

P. O. Address Rock Port. 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.