

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-014354
STATE FILE NUMBER

Registration District No. 175 Primary Registration District No. 303b Registrar's No. 42

AMENDED

FILED MAY 10 1961

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Lawrence</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Aurora Community Hosp.</u> | | Length of stay in 1b <u>11 days</u> | c. CITY OR TOWN <u>Marionville</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Aurora Community Hosp.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>no street address</u> |

| | | | | |
|---|--|--|---|--|
| 3. NAME OF DECEASED (Type or print) First <u>Simon</u> Middle <u>Joseph</u> Last <u>Sowersby</u> | | | 4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1961</u> | |
|---|--|--|---|--|

| | | | | | | |
|--------------------|-------------------------------|--|-----------------------------------|----------------------------------|--|--|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>9/14/1882</u> | 9. AGE (last birthday) <u>78</u> | 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) <u>Miller</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u> | 11. BIRTHPLACE (City and state or country) <u>Macomb, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> |
|---|--|--|---|

| | | |
|--|--|--|
| 13a. FATHER'S NAME <u>Charles James Sowersby</u> | 13b. MOTHER'S MAIDEN NAME <u>Fannie Ferrel</u> | 14. NAME OF HUSBAND OR WIFE <u>Grace Fetters</u> |
|--|--|--|

| | |
|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | 17. INFORMANT <u>Mr. Everett Sowersby, Norwalk, California</u> Address <u>11942 Abingdon,</u> |
|--|--|

| | | |
|--|---|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sanguine, Lower Extremity, Repts.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Atherosclerosis, Generalized.</u> | <u>years</u> |
| | DUE TO (c) _____ | |

| | | |
|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchopneumonia, Bilateral.</u> | | 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 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 <u>April 6, 1961</u> to <u>April 24, 1961</u> and last saw ^{her} him alive on <u>April 24, 1961</u> Death occurred at <u>4:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. |
|--|

| | | |
|--|------------------------------------|---|
| 22a. SIGNATURE (Degree or title) <u>Spennett L. Telsey M.D.</u> | 22b. ADDRESS <u>Aurora, Mo.</u> | 22c. DATE SIGNED <u>April 27, 1961</u> |
|--|------------------------------------|---|

| | | | |
|--|-------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>4/28/1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>IOOF Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Marionville, Missouri</u> |
|--|-------------------------------|--|---|

| | | |
|---|--|--|
| 24. FUNERAL DIRECTOR <u>Jean Harris</u> ADDRESS _____ | 25. DATE RECD. BY LOCAL REG. <u>May 9, 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Minnie McHatt Deputy</u> |
|---|--|--|

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 *J. Alan Harris*

Licensed Embalmer No. 4390

P. O. Address Clever, 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.