

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-020141

STATE FILE NUMBER

AMENDED

Registration District No. 356 Primary Registration District No. 4521 Registrar's No. 52

FILED JUN 7 1961

1. PLACE OF DEATH a. COUNTY <u>TEXAS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>WRIGHT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HOUSTON</u>		Length of stay in 1b <u>8 days</u>	c. CITY OR TOWN <u>MTN. GROVE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>TEXAS CO. HOSPITAL</u>		Inside limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>400 EAST. FRONT</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLEY MONROE DOWDEN</u>			4. DATE OF DEATH Month Day Year <u>MAY 27 1961</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 20 1878</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.	IF UNDER 24 HR Hours <u>7</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (City and state or country) <u>MARSHFIELD MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILEY DOWDEN</u>		13b. MOTHER'S MAIDEN NAME <u>TEE PATTERSON</u>		14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>			
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 <u>MELVIN DOWDEN INDEPENDENCE</u> Address <u>1501 W. STORJ</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>CARCINOMA OF COLON (SIGMOID)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>
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	
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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 5-21-61 to 5-27-61 and last saw ^{her}him alive on 5-27-61
Death occurred at 10:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H. S. Barber, D.D.</u> (Degree & title)		22b. ADDRESS <u>Houston, Mo</u>		22c. DATE SIGNED <u>6-1-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>5-27-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MANES</u>		23d. LOCATION (City, town, or county) (State) <u>MO.</u>
24. FUNERAL DIRECTOR <u>BARBER</u>		ADDRESS <u>MTN. GROVE</u>		25. DATE RECD. BY LOCAL REG. <u>6-6-61</u>
				26. REGISTRAR'S SIGNATURE <u>Melvin Craig</u>

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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 W. W. Barber

Licensed Embalmer No. 3848

P. O. Address W. W. Barber

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, that should be so stated above.