

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-006873

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 157 Primary Registration District No. 6293 Registrar's No. 31

FILED FEB 23 1962

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Jasper</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Carthage Sheridan Twp</b>		a. STATE <b>Mo</b>		b. COUNTY <b>Jasper</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Route 2</b>		Length of stay in 1b <b>60 yrs</b>		c. CITY OR TOWN <b>Carthage</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS <b>Route 1</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>Route 1</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>THOMAS</b>		Middle <b>ALFRED</b>		Last <b>FLOWERS</b>		Month Day Year <b>Feb 11, 1962</b>	
5. SEX <b>male</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>2-12-76</b>	9. AGE (last birthday) <b>86</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>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>		11. BIRTHPLACE (City and state or country) <b>Circleville, Ohio</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>W. A. Flowers</b>			13b. MOTHER'S MAIDEN NAME <b>Louisa Wiggins</b>		14. NAME OF HUSBAND OR WIFE <b>Dorothy Howard Flowers</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>[REDACTED]</b>		17. INFORMANT Address <b>Mrs. Howard Elliott, Rt. 2, Carthage, Mo</b>		
18. CAUSE OF DEATH (Enter only one cause per line)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b>						<b>2 hrs.</b>	
DUE TO (b) <b>Arteriosclerotic heart disease</b>						<b>5 yrs.</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) <b>Pneumonia, acute</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	
Pneumonia, acute <b>10 hrs.</b>							
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>4-14-47</b>		to <b>2-11-62</b>		and last saw her/him alive on <b>2-11-62</b>		Death occurred at <b>11:45 p</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>Charles H. Knell</i> (Degree or title) <b>MD</b>			22b. ADDRESS <b>1515 Hazel, Carthage, Mo</b>			22c. DATE SIGNED <b>2-12-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>2-14-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Paradise Cemetery</b>		23d. LOCATION (City, town, or county) <b>Carthage, Mo</b>		(State)	
24. FUNERAL DIRECTOR <b>KNELL MORTUARY, Carthage, Mo</b>			25. DATE RECD. BY LOCAL REG. <b>2-13-62</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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 Robert H Knell

Licensed Embalmer No. 4459

P. O. Address Carthage, 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.