

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042244

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1671

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 19 1962	
1. PLACE OF DEATH a. COUNTY <u>Greene</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Length of stay in lb <u>28 yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Handley Hospital, ASA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Route 12, Box 73</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First <u>Myrtle</u> Middle <u>Ann</u> Last <u>Dowell</u>	
4. DATE OF DEATH <u>November 9, 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-1897</u>
9. AGE (last birthday) <u>68</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>
11. BIRTHPLACE (City and state or country) <u>Miller Co., Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Elijah Alexander</u>	
13b. MOTHER'S MAIDEN NAME <u>Kate Thornton</u>	
14. NAME OF HUSBAND OR WIFE <u>Bob Dowell</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>	
16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Bob Dowell, Springfield, Missouri</u> Address	
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>Coronary occlusion</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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	
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>11-9-62</u> to <u>11-9-62</u> and last saw her/him alive on <u>11-9-62</u> Death occurred at <u>5:00 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Deceased or filer) <u>[Signature]</u>	22b. ADDRESS <u>Handley Memorial Hosp.</u>
22c. DATE SIGNED <u>11/14/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-13-1962</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Hazelwood Cemetery</u>	
23d. LOCATION (City, town, & county) <u>Springfield Missouri</u>	
24. FUNERAL DIRECTOR <u>Rainey's Chapel, Springfield, Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>11-15-62</u>
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 Nonavon P. Lohm

Licensed Embalmer No. 5159

P. O. Address Springfield, 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.

Permit 11-13-62