WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Henry

Township or Village or City Deepwater (No. St.; Ward)

Registration District No. 361

Primary Registration District No. 4208

File No. 16802

Registered No. 8 9

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME George Fowles

3

PERSONAL AND STATISTICAL PARTICULARS

SEX M

COLOR OR RACE White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) widower

DATE OF BIRTH May (Month) 17 (Day), 1840 (Year)

AGE 77 yrs. 11 mos. 15 ds. If LESS than 1 day, ... hrs. or ... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer & Stone Mason
(b) General nature of industry, business, or establishment in which employed (or employer) Farming

BIRTHPLACE (City or town, State or foreign country) Foreign England

PARENTS

NAME OF FATHER Walter Fowler

BIRTHPLACE OF FATHER (City or town, State or foreign country) England

MAIDEN NAME OF MOTHER Ann Kindu

BIRTHPLACE OF MOTHER (City or town, State or foreign country) England

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O H Haward M D

(ADDRESS) Deepwater

Filed May 2, 191 H. P. Morgan Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ~~April~~ May (Month) 2 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from July 1st, 1917, to May 1, 1918, that I last saw him alive on May 1st, 1918, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Second Attack of Paralysis & old age 82D 162 (Duration) 2 yrs. 6 mos. ds.

Contributory (SECONDARY) over work (Duration) 2 yrs. mos. ds.

8 (Signed) O H Haward M. D.

May 2, 1918 (Address) Deepwater

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL ~~OR REMOVAL~~ Combs Cemetary

DATE OF BURIAL 5-3-1918

UNDERTAKER W. G. McClurn

ADDRESS Deepwater Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County_____

Township _____ Registration District No._____ File No._____

or

Village_____ Primary Registration District No._____ Registered No._____

or

City _____ (NO._____ _____ St.:_____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, 1____
(Month) (Day) (Year)

AGE

____ yrs. ____ mos. ____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)_____

(ADDRESS)_____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h____ alive on _____, 191____, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) ____ yrs. ____ mos. ____ ds.

Contributory _____
(Secondary)

_____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed)_____ M. D.

_____, 191____ (Address)_____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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