LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

19255

1 PLACE OF DEATH

County Henry

Township ..... or Village ..... or City Clinton (NO. 110, ... St., ... Ward)

Registration District No. 350 Primary Registration District No. 3015 File No. ..... Registered No. 140

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Pabk Fowler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: September 15 1845 (Month) (Day) (Year)

7 AGE: 75 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Probate Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Illinois Co Unknown

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Dont Know

12 MAIDEN NAME OF MOTHER: Miss Cummins

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Rudford
(Address) Clinton Mo

15 Filed 7/26, 1920 W. B. Bean Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May 25" (Month) (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 22, 1920, to May 25, 1920 that I last saw h... alive on May 25, 1920 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:
Cystitis from Retained Urine
(Duration) ... yrs. ... mos. 5 ds.
CONTRIBUTORY (Secondary) Enlarged Prostate
(Duration) 10 yrs. ... mos. ... ds.

(Signed) Edi C. Pecker M. D.
5/26, 1920 (Address) Clinton Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Lincoln Cem Clinton — DATE OF BURIAL: May 26, 1920

20 UNDERTAKER: Clinton Mo — ADDRESS

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 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.]

2 FULL NAME .....

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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH .....
(Month) (Day) 1..... (Year)

7 AGE .....yrs.....mos.....ds.

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

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

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH .....
(Month) (Day) 191..... (Year)

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191.....

20 UNDERTAKER | ADDRESS