REC'D APR 15 1938

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

Do not use this space.

1. PLACE OF DEATH
4 County Pendrain
0 Township Wilson
0 City ..... (No. ..... St. ..... Ward)

Registration District No. 72
Primary Registration District No. 5037

File No. 10022
Registered No. 4

2. FULL NAME Edgar Grafton Rowe 000

(a) Residence, No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lily May Vance Rowe

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 3 1872

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
65	10	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monroe Co Mo 0

FATHER

13. NAME Jehial Rowe 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Randolph Co Mo 0

MOTHER

15. MAIDEN NAME Susan Gorham
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Randolph Co Mo

17. INFORMANT (ADDRESS) Eric G Rowe Centralia Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Maple Grove DATE 3/18 1938

19. UNDERTAKER (ADDRESS) M J McDonald Centralia Mo

20. FILED 3/18 1938 J. F. Hickerson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/17 1938

22. I HEREBY CERTIFY, That I attended deceased from 3/17 1938, to 3/17 1938
I last saw him alive on 3/17/38, 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute dilitation	
~~Acute~~ gastritis	
acute	

Other contributory causes of importance: 13C

Name of operation none Date of .....
What test confirmed diagnosis? Phys. Exam. Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) [signature], M. D.
(Address) Centralia, Mo.

12013 -

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

10022

Do not use this space.

1. PLACE OF DEATH
   (a) County Audram — Registration District No. 72
   (b) Township Wilson — Primary Registration District No. 5037 — Registered No. 4
   (c) City ..... (d) Street No. ..... St.
   (If death occurred in Hospital or Institution, write its name instead of street and number)
   (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Edgar Grofter Rowe
   (a) Residence, No. ..... St. ☐ .....
   (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	W	m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	65	10	14	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19 .....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/17, 1938

22. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
acute dilatation	
gastritis, acute	
or dysentery	
dysentery	

Other contributory causes of importance:

13C

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) T. M. Turner, M. D.
(Address) Centralia Mo

SUPPLEMENTARY

REGISTRAR SHALL NOT RECEIVE AFFEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED

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

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....

(b) Township..... Primary Registration District No..... Registered No.....

(c) City..... (d) Street No..... St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME.....

(a) Residence, No..... St. ☐

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as saw mill, bank, etc.....

10. Date deceased last worked at this occupation (month and year).....

11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

17. INFORMANT (ADDRESS).....

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19....

19. FUNERAL DIRECTOR (ADDRESS).....

20. FILED..... 19.....

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) , 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19..... I last saw him alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation ..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?.....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address) .....