

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 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

23 1940

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

12797
Do not use this space.

1. PLACE OF DEATH

(a) County Wright Registration District No. 911
(b) Township Manassas Primary Registration District No. 6227 Registered No. _____
(c) City _____ or _____ (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Geo. R. Rowe
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
6A. IF MARRIED, WIDOWED OR DIVORCED, HUSBAND OF (OR) WIFE OF Dollie E. Rowe
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 6-1857
7. AGE YEARS 82 MONTHS 5 DAYS 27 If LESS than 1 day, _____ hrs. or _____ min.
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. Farmer
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) St. James, Mo.

FATHER 13. NAME John Rowe

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) W. E. Rowe
Elkhart, Ind.

18. BURIAL, CREMATION, OR REMOVAL PLACE Manassas Cemetery DATE March 3, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Russell Barber
Wm. Grove, Mo.

20. FILED April 8, 1940 R. H. Moseley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 3, 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1940, to March 3, 1940
I last saw him alive on March 2, 1940. Death is said to have occurred on the date stated above, at 4:30 A.M.
The principal cause of death and related causes of importance were as follows:

myocarditis (acute)
Other contributory causes of importance: Uremia
Date of onset 1940

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? no
If so, specify _____
(Signed) J. W. Bridges M. D.
(Address) Manassas, Mo.

RECEIVED

District Health Officer No. 6;

District File Number H40-1098

Date Filed APR 11 1940

A2a

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed

Russell Barber

Licensed Embalmer No. 3848

P. O. Address

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12797

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 911

Primary Registration District No. 1227

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wright
(b) ~~City or town~~ Montgomery T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

Geo R. Rowe

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____

(Month) (Day) (Year)

8. AGE:

Years 82 Months 5 Days 27

If less than one day hr. min.

9. Birthplace _____

(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____

(City, town, or county) (State or foreign country)

14. Maiden name _____

(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 3 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death myo Carditis Duration _____

did not see patient at beginning of this trip and could not get much history due to her war and there was suppression of urines
Uremia
Other conditions _____ (Include pregnancy within 3 months of death)
and showed quite a history of uremic poisoning
Major findings: Had been in very poor health for years.
Of operation: Uremia
Uremia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature J. P. Bridges (M. D. or other) _____
Address Manassas signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

S-12797 1940