

Registration District No. 411Primary Registration District No. 2002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jasper 1
(b) City or town Jasper
(c) Name of hospital or institution: Freeman Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: 2 1/2 hrs (Specify whether
In this community _____ (Specify whether
years, months or days) 2 1/2)

3. (a) PRINT
FULL NAME Lowie C. Goewin3. (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
7. Birth date of deceased July 31 1862
(Month) (Day) (Year)

8. AGE: Years 77 Months 10 Days 1 If less than one day
hr. min.

9. Birthplace Northumberland Penn
(City, town, or county) (State or foreign country)10. Usual occupation Insurance Salesman

11. Industry or business _____

12. Name no record
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Florence Goewin(b) Address 410 wall st17. (a) Burial (b) Date thereof Apr 3 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Forest Hills Cemetery18. (a) Signature of funeral director L. C. Mo(b) Address Carroll-Dillon Mortuary19. (a) 4-3-40 (b) Ed W. James
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Jasper
(If outside city or town limits, write "RURAL")
(d) Street No. 410 Wall St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2 1940
year _____ hour _____ minute 2:25 A. M.
21. I hereby certify that I attended the deceased from March
25, 1940 to April 1, 1940
that I last saw her alive on April 1, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to 6 cerebral hemorrhage

Due to _____

Other conditions SAH
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically

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?
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While at work? _____ (Specify type of place) (e) Means of injury _____
Signature A. J. T. Jones (M. D. or other) _____
Address Jasper, Mo. Date signed _____

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.....

Don Petrick

Licensed Embalmer No.....

4008

P. O. Address.....

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