

Registration District No. 218 Primary Registration District No. 3015 Registrar's No. 120

1. PLACE OF DEATH:

(a) County COOPER  
(b) City or town BOONVILLE  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ST JOSEPH HOSPITAL.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 23 DAYS  
(Specify whether years, months or days) 9 mo. 1

3. (a) PRINT FULL NAME ANNA LAURA COWAN.

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 12 - 66  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>4</u>	<u>3</u>	hr. _____ min. _____

9. Birthplace NEB.  
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name IVAN COWAN. ?

13. Birthplace NOT KNOWN (City, town, or county) (State or foreign country)

14. Maiden name LAURA BARD

15. Birthplace NOT KNOWN (City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]

(b) Address NEW FRANKLIN MO.

17. (a) REMOVAL (b) Date thereof 11-16-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST PAUL RAV.

18. (a) Signature of funeral director [Signature]

(b) Address new franklin mo.

19. (a) 11-15-40 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County HOWARD

(c) City or town NEW FRANKLIN  
(If outside city or town limits, write "RURAL") 0

(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 11 day 15  
year 1940 hour 3 minute 30 a.m.

21. I hereby certify that I attended the deceased from Oct 21 1940, to Nov 15 1940  
that I last saw her alive on Nov 14 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration 21 days  
apoplexy cerebral haemorrhage  
Due to Hypertension  
Due to arteriosclerosis

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death) gout

PHYSICIAN \_\_\_\_\_  
Major findings: Of operations none  
Of autopsy none  
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? at

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address New Franklin Mo. Date signed Nov 15 1940

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

NOV. 2-17-39  
U. S. G. 1 X1951

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.

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 12-9-40

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**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.....

*J. L. Hall*

Licensed Embalmer No.....

*3515*

P. O. Address.....

*New Franklin, N.Y.*

**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.**