

FILED FEB 14 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2751

Registration District No. 378

Primary Registration District No. 4222

Registrar's No. 5

1. PLACE OF DEATH:  
 (a) County Howard  
 (b) City or town Fayette  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Free Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 13-14-40-1-17-4  
 (Specify whether  
 In this community Life  
 years, months or days)

3. (a) PRINT FULL NAME Mae Rowland  
 (b) If veteran, name war \_\_\_\_\_ (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 12th 1867  
 (Month) (Day) (Year)

8. AGE: Years 73 Months 6 Days 5 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation At Home

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

MOTHER FATHER { 12. Name Robert A. Rowland  
 18. Birthplace Kentucky (City, town, or county) (State or foreign country)  
 14. Maiden name Olive Keithley  
 15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Martha Wickett  
 (b) Address Fayette, Mo.

17. (a) Burial (b) Date thereof 1-19th 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation City Cemetary

18. (a) Signature of funeral director Guy T. Halley  
 (b) Address Fayette, Mo.

19. (a) 1-18-41 (b) Missouri  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Howard  
 (c) City or town Fayette  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location) 0  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17  
 year 1941 hour 9<sup>00</sup> minute A M.

21. I hereby certify that I attended the deceased from July 1930 to Jan 17 1941  
 that I last saw her alive on Jan 17 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of left breast Duration 3 yrs.

Due to 50

Other conditions Generalized metastasis  
 (Include pregnancy within 3 months of death)

Major findings: Adeno-Carcinoma of left breast  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

341  
 While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature J. W. Shaw (M. D. or other) M.D.  
 Address Fayette, Mo. Date signed 1-18-41

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

30  
 21492

RECEIVED

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 2-13-41

**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 Wm T. Kelley  
Licensed Embalmer No. 2966  
P. O. Address Fayette 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 378

Primary Registration District No. 4222

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Howard  
(b) City or town Fayette  
(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 \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

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.

3. (a) PRINT FULL NAME Mae Rowland

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased July 12 1867  
(Month) (Day) (Year)

8. AGE: Years 73 Months 6 Days 2 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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 \_\_\_\_\_

(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) 1-18-1941 (b) Anna R. ...  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 17  
year 1941 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 \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration

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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Geo W Shaw (M. D. or other) \_\_\_\_\_

Address Fayette Date signed \_\_\_\_\_

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

SUPPLEMENTARY

