

FILED FEB 13 1944  
Registration District No. 3549

Primary Registration District No. 4517

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

1. PLACE OF DEATH:

(a) County Taney  
(b) City or town Branson  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Taney  
(c) City or town Branson  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MINNIE OLA ROWE

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

4. Sex Fem 5. Color or race white 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Guy Nelson Rowe 6. (c) Age of husband or wife if alive 74 years  
7. Birth date of deceased Dec. 5<sup>th</sup> 1863  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
80 1 2 hr. \_\_\_\_\_ min.

9. Birthplace Mangahela Pa. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

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

12. Name Don't know

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

14. Maiden name Don't know

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

16. (a) Informant Guy N. Rowe

(b) Address Branson, Mo.

17. (a) Burial (b) Date thereof Jan 8-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Branson Mo

18. (a) Signature of funeral director P.O. Wheelchel

(b) Address Branson Mo

19. (a) Jan 8-44 (b) Mary Walker  
(If he received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan, day 7  
year 1944 hour 5:00 minute 4 A.M.

21. I hereby certify that I attended the deceased from Dec. 1<sup>st</sup>  
\_\_\_\_\_, 1943 to Jan 7, 1944  
that I last saw her alive on Jan 5<sup>th</sup>, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Nephritis 1 wk.  
Duration  
Due to Senility

Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
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?

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

23. Signature Harry T. Evans (M. D. or other) M.D.  
Address Branson, Mo Date signed 1/7/44

RECEIVED

District Health Officer No. 67

District File Number 244-212

Date Filed FEB 15 1944

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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 Minnie L. Wheelchel

Licensed Embalmer No. 2277

P. O. Address Brunson 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, fact should be so stated above.**

Registration District No. 352 Primary Registration District No. 4517

1. PLACE OF DEATH:

(a) County Janey  
(b) City or town Granson  
(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 \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Minnie La Rose

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 M

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

7. Birth date of deceased see 5 (Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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 \_\_\_\_\_ (Month) (Day) (Year)  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

\_\_\_\_\_

Due to senility

Due to Don't know cause of acute nephritis

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

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

Of autopsy 130

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 H. F. Evans (M. D. or other) \_\_\_\_\_

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

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

SUPPLEMENTAL

FILE

8505