

V. S. No. 2
FORM-8-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 11 1944
Registration District No. 107

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Simpson 31272
State File No. _____
Registrar's No. 374

Primary Registration District No. 3038

58
2.5
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Brookfield
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 years
years, months or days

3. (a) PRINT FULL NAME ADDIE COWAN
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 Samuel Cowan 6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased Jan-1865
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 10 If less than one day _____ min.
9. Birthplace Linn Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
12. Name Wartman & Heese
13. Birthplace Ky
(City, town, or county) (State or foreign country)
14. Maiden name Eliza Murrah
15. Birthplace Va
(City, town, or county) (State or foreign country)

16. (a) Informant Wayne H. Cowan
(b) Address Brookfield Mo

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

(c) Place: burial or cremation Hill Funeral Home
18. (a) Signature of funeral director Hill Funeral Home
(b) Address Brookfield Mo
19. (a) 9-23-1944 (b) W. B. Simpson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Linn 58
(c) City or town Brookfield 1
(If outside city or town limits, write "RURAL")
(d) Street No. 424 E. Sequoia 2
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 14
year 1944 hour 8 minute 50 AM/PM

21. I hereby certify that I attended the deceased from June 1944 to Sept 14 1944
that I last saw her alive on Sept 14 1944
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis 4 mos.
Duration

Due to Senility
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations ✓ 9/24
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? _____

(Specify type of place) While at work? _____ (e) Means of injury? _____
23. Signature W. B. Simpson M. D. or other? DO.
Address Brookfield Date signed 9-15-44

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. H. Blacklock*
Licensed Embalmer No. *2246*
P. O. Address *Brookfield 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.