No. 2
9-4-41
5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13001

FILED MAY 3 1945

Registration District No. 34

Primary Registration District No. 3008

Registrar's No. 115

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

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution State Hosp # 1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since Aug-12-1922 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Montgomery
(c) City or town Rhineland 14
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location) 2
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ellan Dowling

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race W

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 (Month) (Day) (Year)

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace MO (City, town, or county) 0 (State or foreign country)

10. Usual occupation DK

11. Industry or business

FATHER
12. Name Martin Dowling
13. Birthplace Iowa (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Garfo
15. Birthplace DK (City, town, or county) 9 (State or foreign country)

16. (a) Informant Records
(b) Address State Hosp # 1

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4 2 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Rineland

18. (a) Signature of funeral director Bailon Baker
(b) Address Ameriles MO

19. (a) 4-2-1945 (Date received local registrar) (b) Jose Morsinkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 2 year 1945 hour 12 minute 20 P M.

21. I hereby certify that I attended the deceased from 11-20- 1944 to 4-2- 1945 that I last saw h alive on 4-2- 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to Carcinoma

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 55 P

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

23. Signature K. E. Sherrill (M.D. or other)
Address Fulton MO Date signed 4/2/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 5-7-45

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 D B Baker

Licensed Embalmer No. 3375

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 115

1. PLACE OF DEATH:

(a) County Calloway

(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hoop #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since aug. 12-1922 (Specify whether

In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Montgomery

(c) City or town Rhineland
(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 Ellan Dowling

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 2 years

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

8. AGE: Years 64 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Martin Dowling
13. Birthplace Iowa
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Garbe
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hoop #1
(b) Address Fulton Mo

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April Day 2
year 1945 hour 12 minute 20 P M.

21. I hereby certify that I attended the deceased from 9-12, 1944 to 4-2-, 1945
that I last saw h alive on 4-2-, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death chronic mycocarditis

Due to carcinoma left axillary area

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 55 E

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature K. C. Sturgill (M. D. or other)

Address Fulton Mo Date signed 4/2/45

SUPPLEMENTARY

13001