

FILED MAY 2 1945

Registration District No. 175

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13793

State File No. _____

Primary Registration District No. 4276

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Pierce City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Elm Street 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 21 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence
(c) City or town Pierce City 53°
(If outside city or town limits, write "RURAL")
(d) Street No. Elm 4
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joe Daniel Cowan

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Atha Nola Cowan 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased: June 24 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>8</u>	<u>6</u>	hr. _____ min. _____

9. Birthplace Lowell Ark 1
(City, town, or county) (State or foreign country)

10. Usual occupation manager of Lime Co.

11. Industry or business _____

12. Name Jerome Cowan

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

14. Maiden name Rachel Moody

15. Birthplace Kentucky 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Joe Cowan

(b) Address Pierce City Mo

17. (a) Burial (b) Date thereof March 6-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City cemetery

18. (a) Signature of funeral director Wm Wesselt

(b) Address Pierce City Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2
year 1945 hour 10 minute 10 A.M.

21. I hereby certify that I attended the deceased from Dec. 29
1940 to March 2 1945
that I last saw him alive on March 2 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 8 Yrs.
Duration _____

Due to High Blood Pressure

Due to _____

Other conditions (Includes 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 E. B. Wright (M. D. or other) _____

Address Pierce City Mo Date signed 4-5-45

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

RECEIVED

District Health Officer No. 0,

District File Number 445-454

Date Filed APR 19 1943

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 me

Registered Apprentice No.

working under my personal supervision.

Signed

John J. Brown

Licensed Embalmer No.

1512

P. O. Address

Gene City

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. 175

Primary Registration District No. 4276

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

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Pierce city
(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

Joe D. Cowan

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 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 June 2 1945
(Month) (Day) (Year)

8. AGE: Years 65 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) 5-10-45 (b) Eunice Green
(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 May Day 12
Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

13793