

FILED AUG 9 1945

Registration District No. _____

Primary Registration District No. 6892

1. PLACE OF DEATH:

(a) County. SALINE
(b) City or town. MALTA BEND RURAL 2 1/2 miles
(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. 20 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State. MISSOURI (b) County. SALINE 977
(c) City or town. MALTA BEND RURAL
(d) Street No. 6 MI. WEST + NORTH MALTA BEND, MO.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME DELLA MAE FOWLER

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

4. Sex. FEMALE
5. Color or race. WHITE
6. (a) Single, widowed, married, divorced. SINGLE
6. (c) Age of husband or wife if alive. _____ years
7. Birth date of deceased. NOVEMBER 3 1908 (Month) (Day) (Year)

8. AGE: Years 36 Months 8 Days 20 If less than one day hr. min.

9. Birthplace. CARROLL COUNTY ARKANSAS (City, town, or county) (State or foreign country)

10. Usual occupation. NONE

11. Industry or business.
12. Name. MITCHELL L. FOWLER
13. Birthplace. ARKANSAS U.S.A. 1
14. Maiden name. ELIZABETH HOBBS
15. Birthplace. ARKANSAS U.S.A. 1

16. (a) Informant. L.H. FOWLER
(b) Address. INDEPENDENCE MO

17. (a) BURIAL (b) Date thereof. JULY 25 1945 (Month) (Day) (Year)
(c) Place: burial or cremation. MT. NEBO CEMETERY

18. (a) Signature of funeral director. E.S. JAMES
(b) Address. CONCORDIA, MO
19. (a) 7-26-45 (Date received local registrar)
(b) Mat. Weatherston (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23 year 1945 hour 11 minute 4 A.M.

21. I hereby certify that I attended the deceased from on July 23 1945
that I last saw her alive on July 23 1945 and that death occurred on the date and hour stated above.

Immediate cause of death. Heat Exhaustion, also arthritia deformans and chronic myocarditis. Has been bed fast for twenty five years and the heat was to intense for her to stand it.

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

Major findings: Of operations. Of autopsy. 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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature. Waverly (Date signed 7/24/45)
Address. _____

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

7

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MOTHER FATHER

1215

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 8-8-45

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 me

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed

E. S. James

Licensed Embalmer No. 2058

P. O. Address Concordia, 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.