

FILED OCT 31 1945

Registration District No. **381** Primary Registration District No. **3006**

1. PLACE OF DEATH:
 (a) County **Boone**
 (b) City or town **Columbia**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1105 Windsor St. /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: **40 Years** (Specify whether
 In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Boone** **10**
 (c) City or town **Columbia** **2**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **1105 Windsor St.** **4**
 (If rural, give location) **0**
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **NAMES MADISON ROWLAND**
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 **Deliah Goldsberry Rowland** **6. (c) Age of husband or wife if live** _____ years
7. Birth date of deceased **12 - 18 - 1858**
 (Month) (Day) (Year)

8. AGE: Years **86** Months **9** Days **9** If less than one day hr. _____ min. _____

9. Birthplace **Boone County Missouri**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business _____

MOTHER FATHER
12. Name **John D. Rowland**
13. Birthplace **Boone County Missouri**
 (City, town, or county) (State or foreign country)

14. Maiden name **Sarah Pettkum**
15. Birthplace **Boone County Missouri**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. J.M. Rowland**
(b) Address **1105 Windsor St., Columbia, Mo.**

17. (a) Burial (b) Date thereof **9-28-45**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Parsons Funeral Service**
(b) Address **Columbia, Mo.**

19. (a) 9-28-45 (b) **Mrs. R.E. Palmer**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **27**
 year **1945** hour **3** minute **45** **A.** M.

21. I hereby certify that I attended the deceased from **9-26-**
1945 to **9-27-** **1945**
 that I last saw him alive on **9-26-** **1945**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Crownary block** **8 hr.**
 Duration _____

Due to **Age & Indigestion**

Due to _____

Other conditions **Bleed for a long while**
 (Include pregnancy within 3 months of death)

Major findings: **None**
 Of operations _____

Of autopsy **none**

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) **no**
(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? **no**

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

23. Signature **W.P. Bryant** (M. D. or other)
Address **Calumet, Mo.** **Date signed** **9-27-45**

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

DEC 23 1946

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

W. D. Whitaker

Licensed Embalmer No. 3893

P. O. Address Alumina 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.