

FILED MAY 7 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. _____

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 98

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution:
Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days
(Specify whether

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster 112

(c) City or town Elkland Rural 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. R 1 (If rural, give location) 1

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Sowers, William

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex M 0 5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sylvia Sowers

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased July 28, 1876
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>1</u>	<u>23</u>	hr. _____ min. <u>0</u>

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER {

12. Name Sowers, Francis Maurin

13. Birthplace Penn 1
(City, town, or county) (State or foreign country)

14. Maiden name Mary 33 P P P 4
(City, town, or county) (State or foreign country)

15. Birthplace Holland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Sowers, Sylvia

(b) Address Elkland, Missouri

17. (a) Thorge (b) Date thereof 4-26-46
(Date of death or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Thorge

18. (a) Signature of funeral director For Loring

(b) Address Harold Ford Ave

19. (a) 4-27-46 (b) Mrs R E Palmer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23
year 1946 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from April 12
1946 to April 23 1946;
that I last saw him alive on April 23 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure 1 wk.

Due to Hypertension & Chronic nephritis

Due to _____

Other conditions Carcinoma of rectum
(Include pregnancy within 3 months of death)

Major findings: 460

Of operations _____

Of autopsy Carcinoma of rectum, cardiac dilatation

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 R E Northrup M. D. or other

Address State Cancer Hospital Date signed 4-27-46

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

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed..... 5-4-46

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..... *[Signature]*
Licensed Embalmer No. 3312
P. O. Address *Marshfield 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.