S. No. 2
0M—2-43
v. 5-17-39
X35697

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

12166

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 24 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 43357

Registration District No. 1 | Primary Registration District No. 3006 | Registrar's No. 3

1. PLACE OF DEATH:
(a) County: Adair
(b) City or town: Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Laughlin Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Month 24 das (Specify whether years, months or days)
In this community 75 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Adair 3
(c) City or town: Kirksville 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 416 N. High
(If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Jackson I. Fowler
3. (b) If veteran, name war:
3. (c) Social Security No.: None
4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: June (Month) 23 (Day) 1861 (Year)
8. AGE: Years 85 | Months 6 | Days 1 | If less than one day hr. min.
9. Birthplace: New York City (City, town, or county) New York (State or foreign country)
10. Usual occupation: Retired Merchant
11. Industry or business:
FATHER
12. Name: Jackson Philip Fowler
13. Birthplace: New York City (City, town, or county) New York (State or foreign country)
MOTHER
14. Maiden name: Susan Ann Martin
15. Birthplace: West Chester Co., New York (City, town, or county) (State or foreign country)
16. (a) Informant: Philip J. Fowler
(b) Address: Kirksville, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/46 (Month) (Day) (Year)
(c) Place: burial or cremation: Forest Cemetery
18. (a) Signature of funeral director: T E Riley
(b) Address: Kirksville, Missouri
19. (a) 1-16-47 (Date received by local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 24 year 1946 hour 8:30 minute P: M.
21. I hereby certify that I attended the deceased from 19 43, to Dec. 24 19 46 that I last saw him alive on Dec. 24 19 46 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Thrombosis (right)	6 days
Due to: Advanced arteriosclerosis	Years
Due to:	
Other conditions: Senile Dementia (Include pregnancy within 3 months of death)	

Major findings:
Of operations: N/A
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? (Specify type of place)
While at work? (e) Means of injury: 0
23. Signature: J. Don McClure (M. D. or other) DO
Address: Kirksville, Mo Date signed: 12/26/46

(Licensed Embalmer's Statement on Reverse Side)

Office
1.47.146
JAN 23 1947

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 L E Riley

Licensed Embalmer No. H181

P. O. Address Kirkmill

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

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