

No. 2
2-45
17-30
X47070

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

FILED JAN 28 1948

Dr. Gillham

Registration District No. 77

Primary Registration District No. 3016

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 weeks
(Specify whether
In this community 5.5 yrs
years, months or days)

3. (a) PRINT FULL NAME Mrs. Eliza Fowler

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Green C. Fowler 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 10 1858
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>89</u>	<u>4</u>	<u>2</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Benjamin Amos

13. Birthplace Cole County, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Roark

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

16. (a) Informant Richard Fowler

(b) Address Jefferson City, Missouri

17. (a) Burial (b) Date thereof Jan-14-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation River View Cemetery

18. (a) Signature of funeral director Shop & Gordon

(b) Address Jefferson City, Missouri

19. (a) 1-12-48 (b) R. P. Baker MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 26
(c) City or town Jefferson City 5
(If outside city or town limits, write "RURAL")
(d) Street No. 309 A Monroe Street 4
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 12
year 1948 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from Nov 22, 1947, to Jan. 12, 1948.
that I last saw her alive on Jan. 12, 1948.
and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerotic heart disease 6.0K
Duration 5 yr
Due to arteriosclerosis

Other conditions Fractured hip on 11/22/47
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
ADDITIONAL
SUPERVISING
INFORMATION
REQUIRED

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence 1/21
(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)
(a) Means of injury _____

23. Signature Dr. Gillham (M. D. or other) M. D.
Address Jefferson City Mo. Date signed 1/12/48

RECEIVED
DISTRICT HEALTH OFFICER No. 9,
District File Number
Date Filed 1-27-48

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

Ormel Leland Jones Jr

Licensed Embalmer No. *11411*

P. O. Address *Jefferson City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (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. 77 Primary Registration District No. 3066

1. PLACE OF DEATH:

(a) County Colo
(b) City or town Jefferson 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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME: Eliza Fowler
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Wed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Sept 10, 1889
(Month) (Day) (Year)

8. AGE: Years 89 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) No

10. Usual occupation _____

11. Industry or business _____

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 _____ Day _____
year 1948 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 11-22-47

(c) Where did injury occur? Jefferson City - Colo - Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
No

Name _____ (Specify type of place)
While at work? no (e) Means of injury Fell on coaly to bathroom

23. Signature Dr. William M.D. (M. D. or other) M.D.

Address Jefferson City, Mo Date signed 2/4/48

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

SUPPLEMENTARY

MOTHER FATHER

Mr

505
582