

FILED MAR 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9358

| | | | | | | | |
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| BIRTH NO. _____ | | REG. DIST. NO. 248 | | PRIMARY REG. DIST. NO. 4368 | | Registrar's No. 8 | |
| 1. PLACE OF DEATH a. COUNTY <u>Newton</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fairview</u> | | c. LENGTH OF STAY (In this place) _____ | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fairview</u> | | d. STREET ADDRESS (If rural, give location) <u>J</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>A</u> | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>VESTA</u> b. (Middle) <u>MRE</u> c. (Last) <u>Rowton</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 16, 1949</u> | | | | |
| 5. SEX <u>FL</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u> | | 8. DATE OF BIRTH <u>5-6-1919</u> | |
| 9. AGE (In years last birthday) <u>29</u> | | if UNDER 1 YEAR Months <u>10</u> Days <u>10</u> | | if UNDER 11 HRS. Hours <u>10</u> Min. <u>0</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (State or foreign country) <u>Bunker Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Pate Hampton</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Robert R. Rowton</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Robert R. Rowton</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> | | | 16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Liza Russell Fairview Mo</u> | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Burned to death when</u> ANTECEDENT CAUSES DUE TO (b) <u>home burned</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>ca 150</u> <u>6/10</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u> | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u> | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>FAIRVIEW NEWTON Missouri</u> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>3-16-1949 7a. m.</u> | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Home burned completely. Body was found in bed after fire was out.</u> | | | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased <u>live</u> on <u>3-16, 1949</u> , and that death occurred at <u>7a. m.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Corley Thompson Coroner</u> | | | | 23b. ADDRESS <u>Neosho Missouri</u> | | 23c. DATE SIGNED <u>3/16/49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-17-49</u> | | 24b. DATE <u>3-17-49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Dice Cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>Fairview Mo</u> | |
| DATE REC'D BY LOCAL REG. <u>3-21-49</u> | | REGISTRAR'S SIGNATURE <u>Alpha Dyer 369</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. Marshall Jones Wheelock Mo.</u> | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

73000

RECEIVED
District Health Officer No. *15678*
District File Number *8-28-49*
Date Filed

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 _____

working under my personal supervision. *No. Embalmer* Student Embalmer No. _____

Signed _____
Student Embalmer

Signed *Wm Morris Poque*
Licensed Embalmer No. *5447*

P. O. Address *Wheeler, 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.