S. No. 300
v. 10.48

FILED OCT 31 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33457

BIRTH NO. 640103-49 REG. DIST. NO. 104 PRIMARY REG. DIST. NO. 5418 Registrar's No. 35

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

1. PLACE OF DEATH
a. COUNTY: Dunklin
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malden
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Dunklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malden
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): Velma
b. (Middle): Florine
c. (Last): Dowdy

4. DATE OF DEATH (Month) (Day) (Year): Oct. 10 1949

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant
8. DATE OF BIRTH: Oct. 10 1949
9. AGE (In years last birthday): 0 — IF UNDER 1 YEAR: Months 0, Days 0 — IF UNDER 24 HRS.: Hours 5, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: Hershell Dowdy
13b. MOTHER'S MAIDEN NAME: Virgie M. Jones
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: no
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Hershell Dowdy R-1 Malden, Mo.

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) Premature

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 776X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Birth *19___, to* Oct 10 *19*49*, that I last saw the deceased alive on* Oct 10 *19*49 *and that death occurred at* 11 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): S. Oulston RO2
23b. ADDRESS: Malden Mo
23c. DATE SIGNED: Oct 11/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 11-49
24c. NAME OF CEMETERY OR CREMATORY: Malden M. Park
24d. LOCATION (City, town, or county) (State): Malden, Mo.

DATE REC'D BY LOCAL REG.: Oct 22, 1949
REGISTRAR'S SIGNATURE: G. L. Schaumann 87 0
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Dowdy Family

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED OCT 24 1949
District Health Office No. 2
District File Number 1049-1080
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 NOT EMBALMED, working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.