

No. 300  
10-48

40497

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 10 1955

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 98 PRIMARY REG. DIST. NO. 5367 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <b>Daviness</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <b>Missouri</b> b. COUNTY <b>Livingston</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Monroe Township</b>		c. CITY OR TOWN <b>Chillicothe</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>Instant</b>		STREET ADDRESS (If rural, give location) <b>Unknown</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4 Miles South Gallatin</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>George</b>	b. (Middle) <b>Davenport</b>	c. (Last) <b>Fowler</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 30 1954</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March 19 1926</b>	9. AGE (In years last birthday) <b>28</b>	IF UNDER 1 YEAR Months	IF UNDER 11 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dist. Representative</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile Co.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Arcadia Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>James T. Fowler</b>	13b. MOTHER'S MAIDEN NAME <b>Ada M. Davenport</b>	14. NAME OF HUSBAND OR WIFE <b>Georgie V. Fowler</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW 2</b>	16. SOCIAL SECURITY NO. <b>515-18-3278</b>	17. INFORMANT'S SIGNATURE OR NAME <b>James V. Fowler, Ft. Scott, Kan.</b>	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Crushed chest, Multiple bone fractures</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Head on Automobile Collision</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <b>E8104</b> <b>2 to</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway 13</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Monroe Township Daviness Mo.</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>12-30-1954 4Pm.</b>	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Head on Automobile Collision</b>
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22. I hereby certify that I attended the deceased from About, 1954, to 4P, 1954, that I last saw the deceased alive on At Death, 1954, and that death occurred at 4P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Dr. Clements Jr. Dist. Council</b>	23b. ADDRESS <b>Gallatin, Missouri</b>	23c. DATE SIGNED <b>12-31-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>12-31-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>	24d. LOCATION (City, town, or county) (State) <b>Arcadia Kansas</b>
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DATE REC'D BY LOCAL REG. <b>1-3-55</b>	REGISTRAR'S SIGNATURE <b>Virginia M. Engelbert</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>L. O. Rechesseau</b>	ADDRESS <b>Hope Funeral Home, Gallatin, Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

JAN 27 1955

MAY 17 1955

STATE OF IOWA

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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *L.O. Richerson*

Licensed Embalmer No. *339*

P. O. Address *Fallston*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.