

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4216

FILED FEB 11 1958

STATE FILE NUMBER

Registration District No. 360

Primary Registration District No. 3076

Registrar's No. 20

300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Vernon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Nevada		c. CITY OR TOWN Nevada	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 507 S. Cedar		Length of stay in 1b 2 weeks	
d. STREET ADDRESS 507 S. Cedar		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Maude Barrett Rowland			4. DATE OF DEATH Month Day Year January 21, 1958
5. SEX F	6. COLOR OR RACE wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 24, 1874
9. AGE (In years) Last birthdays 83		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) Grant City, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME unknown	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Mose Rowland (deceased)	
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. unknown	
17. INFORMANT Mary L. Barrett		1317 Ad Illinois Ave. Kansas City, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure			INTERVAL BETWEEN ONSET AND DEATH hours weeks weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Post Influenzal Weakening			
DUE TO (c) Virus Influenza			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 481x			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Jan. 3, 58 to Jan. 21, 58 and last saw her alive on Jan. 20, 58 Death occurred at 6:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE A. R. Easton M.D. (Degree or title)		22b. ADDRESS Beachlea Mo	
		22c. DATE SIGNED Feb. 4 58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-29-58	
23c. NAME OF CEMETERY OR CREMATORY City Cemetery		23d. LOCATION (City, town, or county) (State) El Dorado Springs, Mo.	
24. FUNERAL DIRECTOR Ferry Funeral Home, Nevada, Mo.		25. DATE RECD. BY LOCAL REG. 2-7-1958	
		26. REGISTRAR'S SIGNATURE Anna E. Perry	

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. Douglas Ferry*

Licensed Embalmer No. *4960*

P. O. Address *Therapeutic*

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.