

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036144
STATE FILE NUMBER

57204-51
FILED OCT 20 1958

Registration District No. 132 Primary Registration District No. 5475 Registrar's No. 157

1. PLACE OF DEATH a. COUNTY Grundy		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Grundy	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Galt, R. F. D.		c. CITY OR TOWN Galt, R. F. D.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Liberty Twp.		d. STREET ADDRESS (If outside, give location) Liberty Twp.	
3. NAME OF DECEASED (Type or print) R. Franklin Sowers		4. DATE OF DEATH Month Day Year Oct. 14 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17 1958
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months Days Hours Min. 1 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) Chillicothe, Mo		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Fred Sower		13b. MOTHER'S MAIDEN NAME Jackie Baughn	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Fred Sower Address Galt, 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) Cerebral anoxia DUE TO (b) Convulsion DUE TO (c) Birth Injury PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not alluded to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 30 minutes all of its life Aug 17 1958
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 a.m. Month, Day, Year p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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 Oct 1-58 to Oct 14-58 and last saw her/him alive on 7 p.m. Death occurred at 4 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Ann Eitel M.D.		22b. ADDRESS Galt Mo	
22c. DATE SIGNED Oct 15-58		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE Oct. 16 1958		23c. NAME OF CEMETERY OR CREMATORY Harris Cem.	
23d. LOCATION (City, town, or county) Harris, Mo.		24. FUNERAL DIRECTOR P. K. Payne & Son ADDRESS	
25. DATE RECD. BY LOCAL REG. 10-16-58		26. REGISTRAR'S SIGNATURE June Jaur	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *PK Payne Jr*

Licensed Embalmer No. *3400*

P. O. Address *Galt*

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.