

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-043715  
STATE FILE NUMBER

FILED JAN 5 1958 Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 223

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Franklin</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Franklin</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Lonedell</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Francis Hos.</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Dowland</b> Last <b>Dowland</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>28</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1878</b>		9. AGE (In years last birthday) <b>80</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>	11. BIRTHPLACE (City and state or country) <b>London, England</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Walter Dowland</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Beatrice Elphick Dowland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>499-12-0021</b>		17. INFORMANT <b>Beatrice Dowland</b> Address <b>Lonedell, Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Acute Cholerae - with Perforation</b> DUE TO (c) <b>Pneumonia - Lobar - At Home Sake</b>					INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b> <b>17 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pneumonia - Lobar - At Home Sake</b>					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 <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>					
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 <b>12-13-58</b> to <b>12-29-58</b> and last saw <sup>her</sup> alive on <b>12-28-58</b> Death occurred at <b>10:45 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>B. A. Studman</b> (Degree or title) <b>M.D.</b>			22b. ADDRESS <b>Union, Mo</b>		22c. DATE SIGNED <b>12-29-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<b>Burial</b>		<b>Dec. 30, 1958</b>	<b>Oak Grove Cemetery</b>		<b>Lonedell, Missouri</b>
24. FUNERAL DIRECTOR <b>Casey-Lenox</b> ADDRESS <b>St. Clair, Missouri</b>			25. DATE RECD. BY LOCAL REG. <b>12/30/58</b>		26. REGISTRAR'S SIGNATURE <b>B. A. Studman</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JAN 6 1959

### 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 *R. M. Lenot* .....

Licensed Embalmer No. *3601* .....

P. O. Address *St. Clair, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.