Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-047197

STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 446

1. PLACE OF DEATH
a. COUNTY Marion
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Hannibal — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3115 St. Marys Ave — Length of stay in 1b 60 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Marion
c. CITY OR TOWN Hannibal 0644 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 519 Section St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Mary Middle B. Last Rowland

4. DATE OF DEATH Month 12 Day 25 Year 1958

5. SEX Female
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH Nov 14, 1868
9. AGE (In years last birthday) 90 — 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) Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Fayette, Mo.
12. CITIZEN OF WHAT COUNTRY? US

13a. FATHER'S NAME James Swearingen
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Newton Rowland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT J.C. Rowland Address Clearwater, Fla.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerosis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ] 0

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 8-20 58, to 12-25-58 and last saw her/him alive on 12-17-58
Death occurred at 10:35P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J.W. Haidestu M.D.
22b. ADDRESS Hannibal Mo
22c. DATE SIGNED 1-19-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12-30-1958
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) Hannibal (State) Mo.

24. FUNERAL DIRECTOR Clark Funeral Home — ADDRESS Hannibal, Mo.
25. DATE RECD. BY LOCAL REG. 1-19-1959
26. REGISTRAR'S SIGNATURE Dr E M Lucke by H.C. Fisher

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

RECEIVED JAN 26 1959
MARION CO. HEALTH DEPT.
DATE FILED JAN 26 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 Ralph Clark

Licensed Embalmer No. 4217

P. O. Address Hannibal, 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.