

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002355
STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 52
FILED FEB 9 1959

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		c. CITY OR TOWN <u>Sedalia</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1020 West 4th</u>		d. STREET ADDRESS (If outside, give location) <u>1020 West 4th</u>	
Length of stay in lb <u>60 yrs</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>G.</u> Last <u>Cowey</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 7 1872</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13a. FATHER'S NAME <u>William Goff</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Moore</u>		NAME OF HUSBAND OR WIFE <u>Eugene W. Cowey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>E. W. Cowey</u> Address <u>1020 W. 4th</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Severe Congestive Heart Failure</u>		<u>2 weeks</u>
DUE TO (c) <u>Severe dehydration and inanition</u>		<u>4 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Patient refused to eat or drink and had to be kept alive past</u>		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 details in parentheses if possible) <u>2-4-59</u>	
20c. TIME OF INJURY Hour <u>5:40</u> Month, Day, Year <u>Feb. 4, 1959</u> a.m. <u>pm</u>	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 <u>Jan. 5 1958</u> to <u>Feb. 4th 1959</u> and last saw her <u>live</u> on <u>Feb. 4th 1959</u> Death occurred at <u>5:40 pm Feb. 4, 1959</u> in the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Albert J. Campbell Jr.</u> (Degree or Title)	22b. ADDRESS <u>312 1/2 So. Ohio, Sedalia, Mo.</u>	22c. DATE SIGNED <u>2-6-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-6-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>
23d. LOCATION (City, town, or county) <u>Sedalia</u>		(State) <u>Mo</u>

24. FUNERAL DIRECTOR <u>M^cLaughlin Bros</u> ADDRESS <u>Sedalia</u>	25. DATE RECD. BY LOCAL REG. <u>Feb 7 1959</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *K.P.M. Leary*
Licensed Embalmer No. *3153*
P. O. Address *Sodalia, M*

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.