

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006248

STATE FILE NUMBER

FILED FEB 17 1959

Registration District No. 175

Primary Registration District No. 3036

Registrar's No. 14

51
300
1-57

1. PLACE OF DEATH a. COUNTY LAWRENCE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY LAWRENCE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Aurora		c. CITY OR TOWN Aurora	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 137E St Louis		d. STREET ADDRESS (If outside, give location) 137 E. St Louis	
3. NAME OF DECEASED (Type or print) First Middle Last William B. FOWLER		4. DATE OF DEATH Month Day Year Feb. 7-1959	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 20 - 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 83 Months Days Hours Min.
11. BIRTHPLACE (City and state or country) CENTERVILLE Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Thomas FOWLER		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE BERTIE FOWLER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO.	17. INFORMANT Address BERTIE FOWLER Aurora 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) Septicemia			INTERVAL BETWEEN ONSET AND DEATH 24 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Infected Circumstances			24 months
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Emphysema			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 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 June 58 to death and last saw him alive on 2/9/59 Death occurred at 2:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Thomas M. D.		22b. ADDRESS Aurora Mo.	22c. DATE SIGNED 2/9/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/9/59	23c. NAME OF CEMETERY OR CREMATORY Maple Park	23d. LOCATION (City, town, or county) (State) Aurora, Mo.
24. FUNERAL DIRECTOR Oscar L. Marsh ADDRESS Aurora Mo		25. DATE RECD. BY LOCAL REG. 2-10-1959	26. REGISTRAR'S SIGNATURE Ora Mae Natt

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 *Max L. Fossett*

Licensed Embalmer No. *4252*
P. O. Address *Milwaukee*

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.