

FILED FEB 16 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006271

STATE FILE NUMBER

Registration District No. 178 Primary Registration District No. _____ Registrar's No. 9

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Lewis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lewis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Canton</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Canton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At home</u>		Length of stay in lb <u>10 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>302 N. 5th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Frederick</u> Last <u>Towman</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>1959</u>	
--	--	--	---	--

5. SEX <u>Male</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. 24, 1869</u>	9. AGE (In years last birthday) <u>89</u>	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) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Faylis, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	-----------------------------------	---	---

13a. FATHER'S NAME <u>William G. Fowman</u>	13b. MOTHER'S MAIDEN NAME <u>Rebecca Allon</u>	14. NAME OF HUSBAND OR WIFE <u>Anna Lena Collins</u>
--	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Lena Towman, Canton, Mo.</u>	Address _____
---	--	--	---------------

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>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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. _____ p.m. _____	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 <u>Canton Mo</u>	COUNTY _____ STATE _____
---	---	--	--	--------------------------

21. I attended the deceased from <u>Jan 20-59</u> to <u>Feb 8 59</u> and last saw her alive on <u>Feb 8-59</u> Death occurred at <u>0:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE <u>Handwritten Signature</u>	(Degree or title) _____	22b. ADDRESS <u>Canton Mo</u>	22c. DATE SIGNED <u>Feb 9-59</u>
--	-------------------------	----------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-10-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ann Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>New Canton, Illinois</u>
--	-----------------------------	---	--

FUNERAL DIRECTOR <u>Carl H. Buckley, Canton, Mo.</u>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>2-10-'59</u>	26. REGISTRAR'S SIGNATURE <u>P.W. Jennings, M.D.</u>
---	---------------	---	---

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1968 4 14 1971

MAR 3 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 *Earl H. Buckley*

Licensed Embalmer No. *2615*

P. O. Address *Canton, 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.