

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012154  
STATE FILE NUMBER

FILED APR 27 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 125

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Macon</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Macon</b> <sup>c 611</sup> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Laughlin Hosp</b>		Length of stay in 1b <b>10 Days.</b>	d. STREET ADDRESS (If outside, give location) <b>214 Missouri</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Louis K Fower</b>			4. DATE OF DEATH Month Day Year <b>Apr. 18 1959</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>Dec. 12, 1886</b>	9. AGE (In years, last birthday) <b>72</b> UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	11. BIRTHPLACE (City and state or country) <b>Macon, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Frederick Fower</b>		13b. MOTHER'S MAIDEN NAME <b>Doris Schaeffer</b>		14. NAME OF HUSBAND OR WIFE <b>Marguerite Fower</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or class of service) <b>No No.</b>		16. SOCIAL SECURITY NO. <b>494-22-7010</b>	17. INFORMANT Address <b>Mrs. Marguerite Fower Macon, Mo.</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>MASSIVE HEMORRHAGE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4-17-59</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>DUODENAL ULCER 5410</b>		<b>UNKNOWN</b>
	DUE TO (c) <b>(1<sup>st</sup> Hemorrhage 4-17-59 - 2<sup>nd</sup> Hemorrhage 4-18-59)</b>		<b>4-18-59</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Myocardial Ischemia - L. Ventricular Hypertrophy</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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>4-8-59</b> to <b>4-18-59</b> and last saw <sup>her</sup> him alive on <b>4-18-59</b> Death occurred at <b>6:00 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree & title) <b>Louis K Fower</b>		22b. ADDRESS <b>No 2 Burlington, Mo</b>		22c. DATE SIGNED <b>4-20-59</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Apr. 20, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Macon, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Lester Sutton Macon, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>4-20-1959</b>	26. REGISTRAR'S SIGNATURE <b>Dora W. Ratliff</b>	

(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.  
 EARL W. MAISON JR. DO

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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 *Charles L. Hutton*

Licensed Embalmer No. *4577*

P. O. Address *Macon, Ga.*

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.