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DEPARTMENT OF COMMERCE **MO** JUN 11 1941 MISSOURI STATE BOARD OF HEALTH
BUREAU OF THE CENSUS **STANDARD CERTIFICATE OF DEATH**

State File No. **18814**

Registration District No. **743**

Primary Registration District No. **4445**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Ray**
(b) City or town **ORRICK**
(c) Name of hospital or institution: **ORRICK**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **5 1/2 hours** (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Ray** **89**
(c) City or town **ORRICK** **0**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **no** **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Paul Kenneth Rowland**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife **none** 6. (c) Age of husband or wife if alive **2** years
7. Birth date of deceased **5 - 2 - 1941** (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day **5 hr. 30 min.**

9. Birthplace **ORRICK** (City, town, or county) **Mo** (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name **Cecil Raymond Rowland**
13. Birthplace **ORRICK** (City, town, or county) **Mo** (State or foreign country)
14. Maiden name **Luella Frances Wilson**
15. Birthplace **Liberty** (City, town, or county) **Mo** (State or foreign country)

16. (a) Informant **Mrs Raymond Rowland**
(b) Address **ORRICK, Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **5/3/1941** (Month) (Day) (Year)

(c) Place: burial or cremation **Rowland Cemetery**

18. (a) Signature of funeral director **Disposal by family**
(b) Address _____

19. (a) **5/4/1941** (Date received local registrar) (b) **W. D. Campbell, M.D.** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **2** year **1941** hour **12** minute **00** **A** M.

21. I hereby certify that I attended the deceased from **5/2/1941** to **5/2/1941** that I last saw him alive on **5/2/1941** and that death occurred on the date and hour stated above.

Immediate cause of death **Probable atelectasis**

Due to **Prematurity -**

Due to **154**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy **none**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence **None**
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **667**

(Specify type of place) _____ (e) Means of injury _____

23. Signature **W. D. Campbell** (M. D. or other) **OMD**
Address **ORRICK, Mo** Date signed **5/4/41**

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 8,
District File Number 6-4-41
Date Filed

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 Disposal by family, Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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 this body is not embalmed, fact should be so stated above.