N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Stone

Township Lincoln or Village or City

Registration District No. 1044 File No. 31202

Primary Registration District No. 6254 Registered No. 9

(NO. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Henry Clay Bowling

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH Feb 21 1844 (Month) (Day) (Year)

AGE 70 yrs. 6 mos. 7 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Rabson Co Tenn

PARENTS

NAME OF FATHER Benj. Bowling

BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia

MAIDEN NAME OF MOTHER Wilkinson

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Hilton

(ADDRESS) Crane Mo

Filed Sep 15 1914 A Moreland REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 28 1914
Aug (Month) 28 (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 10 1914, to Aug 28 1914, that I last saw h alive on Aug 26 1914, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

97 81

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. L. Kerr M. D.

Aug 29 1914 (Address) Crane Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Maus Hill

DATE OF BURIAL 8-29 1914

UNDERTAKER [redacted]

ADDRESS Crane Mo.

PLACE OF DEATH

County_____

Township _____
or
Village_____
or
City _____ (NO._____ _____ St.;_____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No._____ File No._____

Primary Registration District No._____ Registered No._____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, *1*____
(Month) (Day) (Year)

AGE

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)_____

(ADDRESS)_____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, *191*____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory_____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)_____ M. D.

_____, 191____ (Address)_____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death____ yrs.____ mos.____ ds. In the State____ yrs.____ mos.____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence_____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191____
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.