

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

PLACE OF DEATH

County Shelby Co
Township Edwards
or
Village
or
City Shelbyville (NO. _____ St.; _____ Ward)

Registration District No. 831 File No. 7065
Primary Registration District No. 4504 Registered No. 3

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

FULL NAME George M. Bowser

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)

DATE OF BIRTH March 9, 1946
(Month) (Day) (Year)

AGE 68 yrs. 10 mos. 22 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) Union Ohio

PARENTS
NAME OF FATHER George M. Bowser
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Marah Thur
BIRTHPLACE OF MOTHER (City or town, State or foreign country) England

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. M. Bow

(ADDRESS) Shelbyville
Filed Feb 1 5 1915 W. C. Coover REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan - 31, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 5, 1915, to Jan 31, 1915, that I last saw him alive on Jan 31, 1915, and that death occurred, on the date stated above, at 7:00 pm.

The CAUSE OF DEATH* was as follows:
Nephritis
131

(Duration) 5 yrs. 9 mos. 5 ds.
Contributory (SECONDARY) Infection of L. lower leg
(Duration) 1 mos. 3 ds.
(Signed) P. B. Archer M. D.
Feb 1 1915 (Address) Shelbyville 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 Shelbyville, Mo. DATE OF BURIAL Feb 2, 1915
UNDERTAKER J. Thompson ADDRESS Shelbyville, Mo.

Every item of information should be carefully checked for accuracy. USE OF DEATH in plain terms, so that it may be understood by all.

CIVILIANS should state, if known, in very important.

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____)

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____

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

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
COLOR OR RACE	
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____
AGE	IF LESS than 1 day _____ hrs of _____ min.? _____ yrs _____ mos _____ ds.

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) _____

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 _____ (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 _____
 The CAUSE OF DEATH was as follows:

(Duration) _____ yrs _____ mos _____ ds.

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

(Signed) _____ (Address) _____ M. D.

*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 _____

B. Every item CAUSE OF DEATH

and be stated EXACTLY. PHYSICIANS & Exact statement of OCCURRENCE is very

RECORD

WRITE PLAINLY. WITH FULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIAN SHOULD BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION SHOULD BE GIVEN IN PLAIN TERMS, SO THAT CAUSE OF DEATH CAN BE PROPERLY CLASSIFIED.

PLACE OF DEATH
Shelby

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

County *Shelby* Registration District No. *831* File No. _____
Township _____ or Village _____ Primary Registration District No. *4504* Registered No. *3*
City *Shelbyville* St.: _____ Ward _____

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

FULL NAME *George W Bowers*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *M.* COLOR OR RACE *W.* SINGLE MARRIED WIDOWED OR DIVORCED *M.*
(Write the word)

DATE OF DEATH *Jan. 31, 1915*
(Month) (Day) (Year)

DATE OF BIRTH _____
(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.

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH was as follows:

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

Reproductive Chronic

BIRTHPLACE (City or town, State or foreign country) _____

(Duration) yrs. mos. ds. *Infection of L. Throat*

NAME OF FATHER _____

Contributory (SECONDARY) _____

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

(Signed) *P. C. Arp* M.D.
Shelbyville

MAIDEN NAME OF MOTHER _____

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) _____

Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

Filed *1-29-1915* REGISTRAR

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)