WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

41526

PLACE OF DEATH

County Knox

Township ~~Center~~ or Village ~~Edina~~ or City Edina (NO. ____ St.; ____ Ward).

Registration District No. 1441 File No. ____

Primary Registration District No. 4259 Registered No. 32

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

FULL NAME Infant Boo Rowe

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Nov 21 (Month) (Day) 1916 (Year)

AGE ____ yrs. ____ mos. ____ ds. If LESS than 1 day, 3 hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None

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

BIRTHPLACE (City or town, State or foreign country) Edina Mo

PARENTS

NAME OF FATHER Ewel Bowen

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

MAIDEN NAME OF MOTHER Bertha Hariett

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Chas Kirk

(ADDRESS) Edina Mo

Filed Dec 14 1916. W. J. Jurgens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov (Month) 22 (Day) 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 21, 1916, to ____, 1916, that I last saw h[illegible] alive on 21 Nov, 1916 and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

159; Premature Birth

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Jos Kenney Jr M. D.

Nov 22, 1916 (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 Forest Grove Cem — DATE OF BURIAL Nov 22 1916

UNDERTAKER Kriegshauser Bro — ADDRESS Edina Mo

PLACE OF DEATH

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

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

County _____

Township _____ Registration District No. _____ File No. _____
or
Village _____ Primary Registration District No. _____ Registered No. _____
or
City _____ (No. _____ St.: _____ Ward)

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

FULL NAME Infant

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Nov 21, 1916
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. 2 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) Gilman Ill

PARENTS

NAME OF FATHER Conrad Bonsack

BIRTHPLACE OF FATHER (City or town, State or foreign country) Knox Co. -

MAIDEN NAME OF MOTHER Bertha Hildreth

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

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

Revised United States Standard Certificate of Death

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD