

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

Do not use this space.

23246

1. PLACE OF DEATH

County.....

Registration District No. **7.91**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **6943**

City **St. Louis** (No. **City Hosp # 2**)

St. Ward)

2. FULL NAME

Leola Bowman

(a) Residence. No. **1825 1/2 St.** St. **25** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **4 yrs.** mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Jan. 22, 1927

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, ... hrs. or min.

2

6

7

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

ret

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis, Mo.

10. NAME OF FATHER

Albert Bowman

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

La

12. MAIDEN NAME OF MOTHER

Mildred Progg

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

La

14.

Informant (Address)

Ann J. Woodard City Hospital # 2

15.

File No. 19

277 male 6 Starscof

REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

July 29, 1927

I HEREBY CERTIFY, That I attended deceased from **July 20, 1927** to **July 29, 1927**, that I last saw him alive on **July 28, 1927**, and that death occurred, on the date stated above, at **4:10 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS
Pneumonia

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

not known

19. DID AN OPERATION PRECEDE DEATH? DATE OF

no

20. WAS THERE AN AUTOPSY?

no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Robt. Horneel**, M. D.
19 (Address) **City Hosp # 2**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Greenwood Cemetery

DATE OF BURIAL

Aug. 1, 1927

20. UNDERTAKER

A. L. Beal

ADDRESS

2726 Lucas Ave.

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.

EMERGENCY RECORD

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....

Registration District No. 791

File No. 23246

Township.....

Primary Registration District No. 1003

Registered No. 6943

City St. Louis

(No.)

St. Ward)

2. FULL NAME

Leatha Bowman

(a) Residence. No. St. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 21 Mar 6 Starceff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29 1927

17. I HEREBY CERTIFY That I attended deceased from that I last saw h..... alive on 19....., and that death occurred, on the date stated above at

THE CAUSE OF DEATH WAS AS FOLLOWS:

Bronchopneumonia
Primary information given over
Phone by Dr. L. A. Howell
Rev. of 46 S. 11-9-27 ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRIBUTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

PL ONLY, 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-23246