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

Do not use this space.

26999

1. PLACE OF DEATH
County Greene — Registration District No. 318
Township Springfield — Primary Registration District No. 5439
City or Village Springfield — No. ..... St. ..... Ward)

File No. .....
Registered No. 584

2. FULL NAME J. Fred Bowman

(a) Residence. No. County Farm 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| M | W | Married |

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (or) WIFE OF Mary Bowman (Died)

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 9-1868

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 59 | 5 | 8 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retd. Farmer
(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) Mo

PARENTS

10. NAME OF FATHER Harrison Bowman
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Irene Stackpool
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo

14. INFORMANT Mrs Margaret Bowman
(Address) Springfield Mo

15. FILED 9/27 1927 O Alford Mo
REGISTRAR

## 2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/27/1927

17. I HEREBY CERTIFY, That I attended deceased from 9-12, 1927, to 9-26, 1927, that I last saw h[illegible] alive on 9-26, 1927, and that death occurred, on the date stated above, at 9.00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Posterior Sclerosis
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Gastro intestinal
80
1208
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J R Rensbart, M. D
9-27, 1927 (Address) Springfield, Mo

*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 |
|---|---|
| Greenlawn Cem. | 9/28 1927 |
| 20. UNDERTAKER | ADDRESS |
| Alma Lohmeyer | Springfield |

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.