

SEP 25 1928

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

Do not use this space
Adams
27035

1. PLACE OF DEATH
 County *Drew* Registration District No. *318*
 Township *Springfield* Primary Registration District No. *7001*
 City *Springfield* No. *945* Douglas St. Registered No. *618* (Ward)

2. FULL NAME *Mrs Rosa Bowler*
 (a) Residence *745 No Douglas* Ward. (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 *Female*
 4. COLOR OR RACE *White*
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *At 29 1862*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR)
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
65 10 1
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Housewife*
 (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) *Missouri*
 10. NAME OF FATHER *Unknown*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*
 12. MAIDEN NAME OF MOTHER *Anderson*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*
 14. INFORMANT *H. Lohmeyer*
 (Address) *Springfield, Mo*
 15. FILED *8/31, 1928* Registrar *O. H. H. H. H.*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8-30 1928*
 17. I HEREBY CERTIFY That I attended deceased from *4-13* 19*28* to *8-30* 19*28*, and that I last saw h. or alive on *8-29* 19*28*, and that death occurred, on the date stated above, at *131* m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic - Intestinal Nephritis
several yrs. unable to
defecate (duration) yrs. mos. ds.
 CONTRIBUTORY *Permeable Arterio* (SECONDARY) (duration) *4* yrs. mos. ds.
 18. WHERE WAS DISEASE CONTRACTED *At home*
 IF NOT AT PLACE OF DEATH
 19. DID AN OPERATION PRECEDE DEATH? *NO* DATE OF...
 WAS THERE AN AUTOPSY? *NO*
 WHAT TEST CONFIRMED DIAGNOSIS? *Laboratory*
 (Signed) *Delia P. Webb, M.D.*
8-30, 1928 (Address) 742 Kansas, Redg.
 *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 *Springfield* DATE OF BURIAL *8/31 1928*
 20. UNDERTAKER *H. H. H. H.* ADDRESS *Springfield*

WRITE IN INK 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.

