68

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

Do not use this space.

1. PLACE OF DEATH
County: Montgomery — Registration District No. 571 — File No. 34467
Township: Walker — Primary Registration District No. 5769 — Registered No. 59
City ..... (No. ..... St. ..... Ward)

2. FULL NAME: Henry Bowes
(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: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 3 1854

7. AGE: Years 74 — Months 10 — Days 11 — 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) Mo.

PARENTS
10. NAME OF FATHER: Jacob Bowes
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER: Bally
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ind.

14. INFORMANT: T. H. Bowes
(Address) California Mo

15. FILED: Oct 15 1929 — Jas W. Roth, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 10-14- 1929

17. I HEREBY CERTIFY, That I attended deceased from Several months, 19..., to ..., 19..., that I last saw him alive on 10-14 1929, and that death occurred, on the date stated above, at 11 9 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
" Nephritis
131 (duration) ..... yrs. ..... mos. ..... ds.
93C
CONTRIBUTORY (SECONDARY) 1290 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) [signature], M. D.
10-15, 1929 (Address) California 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: Crown Hill, California Mo. — DATE OF BURIAL: Oct 16 1929

20. UNDERTAKER: J. W. Wilson & Son — ADDRESS: California Mo

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.