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

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1. PLACE OF DEATH

County Texas — Registration District No. ..... — File No. .....

Township ..... — Primary Registration District No. ..... — Registered No. 23

City Houston mo (No. ..... St. ..... Ward)

2. FULL NAME Leola Bowen

(a) Residence. No. Akers Mo. St., X Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 5 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)
Female	White	

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.
	2	5		

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) Hartshorn
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Leon Bowen

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

12. MAIDEN NAME OF MOTHER Velma Derryberry

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

14. INFORMANT Ida B Smith
(Address) Hartshorn Mo.

15. FILED 10-24 1929 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-24- 1929

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on 10-24-, 1929, to ....., 19..., that I last saw her alive on 10-24-, 1929, and that death occurred, on the date stated above, at 10:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Undetermined

205B

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 205B

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) E. C. Blankenship, 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
Central	10-25 1929
20. UNDERTAKER G. D. Elliott	ADDRESS Houston

N. B.—Every item of information should be carefully supplied. [illegible] 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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Texas — Registration District No. 863 — File No.
Township — Primary Registration District No. 4522 — Registered No.
City Houston (No. , St. Ward)

2. FULL NAME Leola Bowen
(a) Residence. No. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)
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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Can't give any further particulars as they just dropped in an out.

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

7. AGE: YEARS 2 — MONTHS 5 — DAYS [illegible] — 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)

PARENTS
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 10-24 1929 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 24 1929

17. I HEREBY CERTIFY, That I attended deceased from 19 to , 19 that I last saw h alive on , 19 , 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.

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) , 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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

N. B.— [illegible] of information should be carefully supplied. AGE [illegible] should be stated EXACTLY. PHYSICIANS should state CAUSE [illegible] TH in plain terms, so that it may be properly [illegible]d. Exact statement of OCCUPATION is very important.

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

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