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

Do not use this space.

43153

1930

1. PLACE OF DEATH

County: Shelby — Registration District No.: 830 — File No.: 2

Township: Salt River — Primary Registration District No.: 6091 — Registered No.:

City: Shelbina (No. ..... St. ..... Ward)

2. FULL NAME: Albert Thornton Bowling

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 12 – 1860

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	70	6	15	

8. OCCUPATION OF DECEASED

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

(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

PARENTS

10. NAME OF FATHER: Albert Thornton Bowling

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

12. MAIDEN NAME OF MOTHER: Gaby N.

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

14. INFORMANT: Mrs. Irving Ahern
(Address): Shelbina Route

15. FILED: Feb. 15 1930 Mae Goodpasture, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12-27- 1929

17. I HEREBY CERTIFY, That I attended deceased from 12-27- 1929, to 12-27- 1929, that I last saw h. alive on 12-27-29, 19..., and that death occurred, on the date stated above, at 9 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute dilatation of Heart
59
95B
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Diabetes + Cystitis
(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? no.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) A. McWord, M. D.
12-29, 19 (Address) Shelbina 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: Catholic cemetery Shelbina — DATE OF BURIAL: 12-30 1929

20. UNDERTAKER: J B Brothers — ADDRESS: Shelbina 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD