

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

8248

1. PLACE OF DEATH

County Dunklin
 Township Freedom
 City Clarkston (No. _____)

Registration District No. 284
 Primary Registration District No. 5403

File No. _____
 Registered No. 7
 St. _____ Ward _____

2. FULL NAME

Walter Bowman

(a) Residence. No. _____ St. _____ Ward _____
 (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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 22nd 1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
26 10 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Ky.
 (STATE OR COUNTRY)

10. NAME OF FATHER Wm Lee Bowman

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

12. MAIDEN NAME OF MOTHER Rodie B Harshman

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

14. INFORMANT W L Bowman
 (Address) Clarkston Mo

15. FILED 3-5-30 J B Stearns
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-5 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-21, 1930, to 3-5, 1930, that I last saw him alive on 3-5, 1930, and that death occurred, on the date stated above, at 2:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

T. B. Meningitis23A24A(duration) 3 yrs. 8 mos. 8 ds.

CONTRIBUTORY Pulmonary T. B.
 (SECONDARY)

(duration) 7 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? X-Ray & microscope
 (Signed) J. B. Stearns, M. D.

(Address) Clarkston 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

Standfield3-6 1930

20. UNDERTAKER

ADDRESS

Geo ThompsonClarkston

