DEC 22 1930

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

Do not use this space.

36471

1. PLACE OF DEATH
County Jackson   Registration District No. 400   File No.
Township Prairie   Primary Registration District No. 7737 B   Registered No. 147
City Little Blue   (No. Jackson Co Home St. Ward)

2. FULL NAME James E. Bowman
(a) Residence. No. Jackson County Home 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	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-18-1860

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
70	8	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) unknown
(c) Name of employer unknown

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

PARENTS
10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) unknown

14. INFORMANT J W Hostetter
(Address) Jackson Co Home

15. FILED Nov 18 1930   W. S. James   REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-2-1930

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Nov 2, 1930
that I last saw h— alive on Oct 31, 1930, and that death occurred, on the date stated above, at 1 o'clock a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
(duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (SECONDARY) ....(duration) ....yrs. ....mos. ....ds.

10 B

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) J. W. Greene M.D.
11/3, 1930 (Address) Independence 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
K C School of Phy & Surgeons 7th Street	11/18 1930
20. UNDERTAKER	ADDRESS
Katterlin	K C 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.