

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

Do not use this space.

1868

**1. PLACE OF DEATH**

County Knox  
Township Center  
City Edina (No. ....)

Registration District No. 441  
Primary Registration District No. 4259

File No. ....  
Registered No. 23  
St. .... Ward)

**2. FULL NAME**

Mary Elizabeth Bowen

(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 Female 4. COLOR OR RACE Am. Wh 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) Jan. 4, 1931

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
6 yrs. 30 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) Edina  
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Kenneth Bowen

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Knox Co. Mo.  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Irene Mettes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Macou Co. Mo  
(STATE OR COUNTRY)

14. INFORMANT W.H. Landfalter  
(Address) Edina Mo.

15. FILED 1-9-31 Yeast Brown  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1931, to Jan 4, 1931, that I last saw her alive on Jan 4, 1931, and that death occurred, on the date stated above, at 4:30 P. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Prematurity - 7 months  
159

CONTRIBUTORY (SECONDARY) 161 (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) W.H. Landfalter, M. D.  
Jan 5, 1931 (Address) Edina, 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 Lincoln Cemetery DATE OF BURIAL Jan 5 1931

20. UNDERTAKER W.H. Landfalter ADDRESS

K. 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.



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REGISTRAR: WILL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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 Jenox  
Township Edina  
City Edina

Registration District No. 441  
Primary Registration District No. 4259

File No. ....  
Registered No. 83  
St. .... Ward)

2. FULL NAME

(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)

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- (a) Trade, profession, or particular kind of work  
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9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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 1-9-31

Geo. Brown  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 19 31

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., and that I last saw him alive on ..... 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

Linville Cemetery Jan 5 19 31

20. UNDERTAKER

L. B. Kelly Edina, Mo.

8981-5