

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

Do not use this space.

1. PLACE OF DEATH

5 County Barry
Township Center
City Center (No. _____)

Registration District No. 34
Primary Registration District No. 6239

File No. 7292
Registered No. 3
St. _____ Ward _____

2. FULL NAME

Laura Belle Bowman

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 15 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-11-1914

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>77</u>	<u>6</u>	<u>28</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Center
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Frank Prattix

11. BIRTHPLACE OF FATHER (CITY OR TOWN) D.K.
(STATE OR COUNTRY) Tenn

12. MAIDEN NAME OF MOTHER Elizabeth Howard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) D.K.
(STATE OR COUNTRY) Tenn

14. INFORMANT Hilden Bowman
(Address) Center, Mo.

15. FILED 3-11-1932 Ms. H. P. Seary
REGISTER

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-9-1932

17. I HEREBY CERTIFY, That I attended deceased from Mar. 8, 1932, to Mar 9, 1932, that I last saw h. or alive on Mar 9, 1932, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Solar Infection
IIA
108 (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Influenza
(SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
WAS THERE AN AUTOPSY _____
WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Hermot H. Sawyer M. D.
Cassville, Mo. 3-11-1932 (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 Concord Cemetery DATE OF BURIAL 3-11-1932

20. UNDERTAKER Barrett & Sons ADDRESS Center, 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.

APR 23 1932

WHILE I LIVE, WITH UNFADING INTEREST, THIS IS A PERMANENT RECORD

