

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35965

State File No. _____

Registration District No. 266

Primary Registration District No. 5347

Registrar's No. 71

1. PLACE OF DEATH:

(a) County Dent
(b) City or town Rural Meramac
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Mary Catherine Bowers

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife James Bowers 6. (c) Age of husband or wife if alive 83 years
7. Birth date of deceased April 10 1856
(Month) (Day) (Year)

8. AGE: Years 83 Months 6 Days 1 If less than one day hr. _____ min. _____

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Jack Butts
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Winnetta Bowers
(b) Address Salem, Missouri

17. (a) Burial (b) Date thereof 10/12/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bowers Cemetery

18. (a) Signature of funeral director Carl X. Spencer
(b) Address Salem, Missouri

19. (a) Oct 12/39 (b) F. E. Jeffery MD 240
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11
year 1939 hour 1:20 minute A M.

21. I hereby certify that I attended the deceased from Oct 8, 1939, to Oct 8, 1939,
that I last saw her alive on Oct 8, 1939,
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis with possible malignancy in region of Gall bladder
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy None

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature F. E. Jeffery (M. D. or other) MD
Address Salem, Mo Date signed 10/12/39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~and~~

Registered Apprentice No.

working under my personal supervision.

RECEIVED

District Health Officer No. 5.

District File Number. 1139390

Date Filed 11839

Signed

Wm. W. McDonald

Licensed Embalmer No.

3806

P. O. Address

Salem, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.