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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

7863

STANDARD CERTIFICATE OF DEATH ✓

State File No. 2

Registration District No. 732

Primary Registration District No. 4437

Registrar's No. 732

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048  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Higbee Mo.  
(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) 2

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. (a) PRINT FULL NAME Mrs Agnes Bowman

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

4. Sex Female 5. Color or race White 6. (e) Single, widowed, married, divorced Divorce

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 9th 1876  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

|    |   |    |          |
|----|---|----|----------|
| 64 | I | IO | hr. min. |
|----|---|----|----------|

9. Birthplace Scotland 4  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife 4

11. Industry or business 4

MOTHER FATHER { 12. Name Cochran Ballentine

13. Birthplace Scotland (City, town, or county) (State or foreign country)

14. Maiden name Christine McClay

15. Birthplace Scotland (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Tom Jennings

(b) Address Higbee Mo

17. (a) Burial (b) Date thereof Feb 21 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial City Cem Higbee Mo

18. (a) Signature of funeral director Joe W Burton

(b) Address Higbee Mo

19. (a) Feb. 29-1940 (b) J.W. Wilson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

(c) City or town Higbee Mo.  
(If outside city or town limits, write "RURAL")

(d) Street No. 0  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? About 50 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 2-19-40  
year \_\_\_\_\_ hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb 7 1940  
\_\_\_\_\_ 19 \_\_\_\_\_ to Feb 19 1940  
that I last saw her alive on Feb 19 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia 1 wh

Due to surgical shock from broken bones left arm

Due to Feb 7 1940

Other conditions (Include pregnancy within 3 months of death) 10 10

Major findings: Of operations 10 10

Of autopsy \_\_\_\_\_

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) Yes, indirectly

(b) Date of occurrence Feb 21 1940

(c) Where did injury occur? Higbee Randolph Co Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home

While at work? Yes (Specify type of place) (e) Means of injury Broken bones

23. Signature W.H. Albrecht (Date received local registrar) 3

Address Higbee Mo Date signed 2-29-40

JUL 23 1947

RECEIVED

District Health Officer No. 10

District File Number 3-40-496

Date Filed MAR 16 1940

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, or by M. J.

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Carl Roberson

Licensed Embalmer No. 4101

P. O. Address Highland, 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **7863**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **732**

Primary Registration District No. **4439**

Registrar's No. ....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Randolph**

(b) City or town **Neodesha**  
(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..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME **Mrs Agnes Bowman**

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

4. Sex..... 5. Color or race.....

6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

**64** **1** **10** .....

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (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.

20. DATE OF DEATH: Month **Feb** day **29** year **1940** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19..... that has now h..... alive on..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial Pneumonia**

Due to **Surgical shock from Broken bones of left arm**

Due to **arm**

**Feb 2 1940**

Other conditions..... (Include pregnancy within 3 months of death)

**Broken bones of four major fingers; Of arm were sustained in an accidental fall at home.**

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) **Accident**

(b) Date of occurrence **Feb 2, 1940**

(c) Where did injury occur **at her home Neodesha Randolph Mo.** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Home** (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature **W. V. Dueden** (M. D. or other) Address **Neodesha**

SUPPLEMENTARY

