

Registration District No. 334Primary Registration District No. 5465Registrar's No. 23

1. PLACE OF DEATH:

- (a) County HARRISON
 (b) City or town BETHANY TOWNSHIP
 (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) 7

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

In this community
years, months or days)3. (a) PRINT FULL NAME JOHN BENJAMIN FRANKLIN Mc GOWAN3. (b) If veteran,
name war3. (c) Social Security
No.4. Sex M 5. Color or race W 6. (a) Single, widowed, married,
divorced widowed6. (b) Name of husband or wife Lula 6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased 11 17 1859
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

80323

hr. min.

9. Birthplace HARRISON COUNTY Mo. 0
(City, town, or county) (State or foreign country)10. Usual occupation FARMER

11. Industry or business

12. Name JOHN Mc GOWAN13. Birthplace INDIANA (State or foreign country)14. Maiden name EMMIE JONES (State or foreign country)15. Birthplace OHIO (State or foreign country)16. (a) Informant's own signature Rt Mc Gowan(b) Address Bethany, Mo.17. (a) BURIAL (b) Date thereof 3/12/40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation SPRINGER CEMETERY18. (a) Signature of funeral director L. M. Haas 253(b) Address Bethany, Mo.19. (a) 3-13-40 (b) A. R. Wessling
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County HARRISON(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 MARCH day 10
year 1940 hour 11 minute 30 A. M.21. I hereby certify that I attended the deceased from March
10, 1940, March 10, 1940
that I last saw him alive on March 10, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Bronchopneumonia

Duration

4da.

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

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) ✓(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 Ralph L. Walker (M. D. or other) D.O.Address Bethany, Mo Date signed 3/13/40

RECEIVED
District Health Officer No. 11,
District File Number 440-520
Date Filed APR 12 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.....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.