APR 23 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11476

Registration District No. 481 Primary Registration District No. 5611 Registrar's No.

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

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town ELDREDGE TWP (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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Laclede
(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.

3. (a) PRINT FULL NAME ROBY C. BOWMAN 558
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife LENA SHUMATE
6. (c) Age of husband or wife if alive years
7. Birth date of deceased APR (Month) 14 (Day) 1862 (Year)
8. AGE: Years 78 Months 10 Days 20 If less than one day hr. min.
9. Birthplace Johnson Co (City, town, or county) TENN (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name WASHINGTON BOWMAN
13. Birthplace TENN (State or foreign country)
MOTHER 14. Maiden name MARTHA OSBORNE
15. Birthplace TENN (State or foreign country)
16. (a) Informant's own signature Hiloy Jones
(b) Address 217 N Kansas Ave Springfield Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation ZION CEMETARY
18. (a) Signature of funeral director Palmer
(b) Address Lebanon, Mo
19. (a) April 1 (Date received local registrar) (b) Nara Cole (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 4 year 1940 hour 5 minute P. M.
21. I hereby certify that I attended the deceased from Feb 1-40 Mar 4, 1940, to Mar 4, 1940, that I last saw him alive on Mar 3, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Flu - Bronchitis Pneumonia —	1940
Due to	
Due to 11N	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations none	
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? 406
(Specify type of place)
While at work? (e) Means of injury
23. Signature E. J. Clemboe M.D. (M.D. or other)
Address Conway Date signed 3-21-40

(Licensed Embalmer's Statement on Reverse Side)

50M-5-17-39 Rev. 5-17-39

RECEIVED
District Health Officer No. 7,
District File Number 4-40-37
Date Filed 4-8-40

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.

No. 2B
-?-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11476

Registration District No. 451 Primary Registration District No. 3616 Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon Twp
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Laclede
(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.

3. (a) PRINT FULL NAME Roby C. Bowman
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) apr (Day) 14 (Year) 1862

8. AGE: Years 77 Months 10 Days 20 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) April 1 1940 (Date received local registrar) (b) Nora Cole (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 4
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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 E. L. Claborne (M. D. or other)
Address Camdenton Date signed Mar

SUPPLEMENTARY

11476 (1940)