

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24461

State File No.

Registrar's No. 176

Registration District No. 1

Primary Registration District No. 1

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Kennett
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Home - Smith
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 hours
 (Specify whether
 In this community 12 hours
 years, months or days)

3. (a) PRINT FULL NAME Mabel Alice Collins Bowen 500

3. (b) If veteran, name war 0 3. (c) Social Security No. 0

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Theodore Conley Bowen 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased April 2, 1910
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 3 29 hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name Thomas H. Collins

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

14. Maiden name Christine Hunter

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

16. (a) Informant Mr. Pharras H. Collins

(b) Address La Plata, Mo.

17. (a) Burial (b) Date thereof July 29, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation La Plata

18. (a) Signature of funeral director D. J. Hunter
 (b) Address La Plata, Mo.

19. (a) July 31/40 (b) Spencer L. Freeman
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
 (c) City or town La Plata
 (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 July day 27
 year 1940 hour 6 minute 35 A.M.

21. I hereby certify that I attended the deceased from 7-26
 1940, to 7-27, 1940;

that I last saw her alive on 7-27, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebellar tumor (Brain) Duration 3 months

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? _____

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

23. Signature [Signature] (M. D. or other) MD
 Address Winchester, Mo. Date signed 7-27-40

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

55-19
DEC 25 1941

RECEIVED

District Health Officer No. 10

District File Number 8-40-1648

Date Filed AUG 15 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24461

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 1

Primary Registration District No. 1

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Keirsville
(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 _____
In this community _____ (Specify whether
years, months or days)

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.

3. (a) PRINT FULL NAME

Label Alice Collins Bowen

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex f 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) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 3 29 hr. min.

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)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sept. 9/1940 (b) Spencer L. Freeman (c) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ 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.

Immediate cause of death Cerebellar Tumor
(Brain)
No operation - Kind of Tumor
Due to Unknown

Due to _____

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

Major findings: Of operations _____

Of autopsy None

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 _____

Signature J. Wimp (M. D. or other)

Address Kirksville Mo Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

