

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

State File No. **28647**

SEP 19 1940

Registration District No. **380**

Primary Registration District No. **4224**

Registrar's No. **12**

1. PLACE OF DEATH:

(a) County **Howard**
(b) City or town **New Franklin**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Howard St.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community **Life**
years, months or days (Specify whether)

3. (a) PRINT
FULL NAME

Margaret Cosby Bowman

3. (b) If veteran,

name war

3. (c) Social Security

No. **None**

4. Sex

Female

5. Color or
race **White**

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

6. (b) Name of husband or wife

Wm. Taylor Bowman

6. (c) Age of husband or wife if

alive **81** years

7. Birth date of deceased

June 21 1865

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

75

1

28

hr. min.

9. Birthplace

New Franklin Mo.

(City, town, or county)

(State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

John Gregory Berndon

13. Birthplace

Va.

(City, town, or county)

(State or foreign country)

14. Maiden name

Lucy Strange

(City, town, or county)

(State or foreign country)

15. Birthplace

Va.

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature

M. Bowman

(b) Address

New Franklin Mo.

17. (a)

Burial

(b) Date thereof

8/12/40

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

mt Pleasant

18. (a) Signature of funeral director

J. S. Whisenand

(b) Address

New Franklin

19. (a)

Aug 30, 1940

(b)

Clare T. Landrum

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Howard**
(c) City or town **New Franklin, Mo.**
(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 **Aug** day **17**
year **1940** hour **8** minute **05 P.M.**

21. I hereby certify that I attended the deceased from
Jan 1, 19**40**, to **Aug 17**, 19**40**.
that I last saw him alive on **Aug 17**, 19**40**.
and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma Stomach

Duration

9 mo

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

23. Signature **Chas. J. Chamberlain** (M. D. or other)
Address **New Franklin Mo.** Date signed **Aug 30 1940**

RECEIVED
District Health Officer No. 8
District File Number
Date Filed

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

H. B. Hall

Licensed Embalmer No.

3515

P. O. Address

New Franklin,

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.