

Registration District No.

Primary Registration District No. 1

Registrar's No.

255

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Kirkville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: A. S. O. Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 16 Hours
(Specify whether years, months or days)
 In this community 4 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
 (c) City or town Kirkville
(If outside city or town limits, write "RURAL")
 (d) Street No. 411 E. Jefferson
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME Adra Genevieve Bowen

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

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

6. (b) Name of husband or wife David A. Bowen 6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased December 9, 1914
(Month) (Day) (Year)

8. AGE: Years 25 Months 10 Days 19 If less than one day hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Domestic

MOTHER FATHER { 12. Name Charles Richards

18. Birthplace Filmore Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Emma Leilah Hawkins

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

16. (a) Informant David A. Bowen

(b) Address 411 E. Jefferson

17. (a) Burial (b) Date thereof 10-30-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivett Cem.

18. (a) Signature of funeral director Davis Funeral Home

(b) Address Kirkville, Missouri

19. (a) Nov. 4, 1940 (b) Spencer L. Freeman
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28 year 1940 hour 12 minute 00A.M.

21. I hereby certify that I attended the deceased from Oct 25 to Oct 28, 1940, that I last saw her alive on Oct 28, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death hemorrhage from amplex placenta
 Due to toxaemia of pregnancy

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Abruptio Placenta

Of autopsy _____

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 Spencer L. Freeman (M.D. or other) _____
 Address Kirkville Date signed 10/29/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

148

AUG 4 1948

AUG 31 1948

RECEIVED

District Health Officer No. 10

District File Number 11-40-2138

Date Filed NOV 14 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 Harold V. Vogel

Licensed Embalmer No. 4076

P. O. Address Kirkville, 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **34649**

Registration District No. **1**

Primary Registration District No. **1**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Adair**
(b) City or town **Waverly**
(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

3. (a) PRINT FULL NAME **Adra Genevieve 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 **25** Months **10** Days **19** If less than one day _____ 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)

(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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Oct** day **28** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Hemorrhage from abruptio placentae**

Due to **Toxemia Pregnancy**

Due to _____
Other conditions _____ (Include pregnancy within 3 months of death) **149.0**

Major findings: Of operations **Cesarian Section N.M.D.**
Of autopsy _____

Duration _____
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 **J. H. [unclear]** (M. D. or other) _____
Address **Waverly** Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

