

FILED MAY 9 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15103

State File No.

Registration District No. 518 Primary Registration District No. 5694 Registrar's No.

1. PLACE OF DEATH:

- (a) County McDonald
 (b) City or town Anderson Rural McMillian
 (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 80 yrs years, months or days)

3. (a) PRINT FULL NAME Mary E. Bowman

3. (b) If veteran, name was XXXXXXXXXXXXXX 3. (c) Social Security No. XXXXXXXXXX

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

6. (b) Name of husband or wife L.A. Bowman 6. (c) Age of husband or wife if alive XXXXXX years

7. Birth date of deceased December 23 1860
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 3 24 hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home

- MOTHER FATHER { 12. Name A.G. Sherman
 13. Birthplace Ill. (City, town, or county) (State or foreign country)
 14. Maiden name Mary Dunnehy
 15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Orville Bowman
 (b) Address Anderson Mo.

17. (a) Burial (b) Date thereof 4-19-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Anderson Cemetery
 18. (a) Signature of funeral director M. D. Snow
 (b) Address Anderson, Missouri

19. (a) 4-19-41 (b) Mrs. Lee Hopper
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County McDonald
 (c) City or town Anderson
 (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. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 17 year 1941 hour 8.45 minute M.

21. I hereby certify that I attended the deceased from Apr 17 to Apr 17, 1941,
 that I last saw him alive on Apr 14, 1941,
 and that death occurred on the date and hour stated above.

- Immediate cause of death Myocardial infarction

- Due to Coronary artery disease

- Due to Coronary artery disease

- Other conditions none
 (Include pregnancy within 3 months of death)

- Major findings:
 Of operations none

- Of autopsy none

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) ind
 (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?

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

23. Signature S. B. Pinski (M. D. or other)
 Address Anderson Mo Date signed 4/18/41

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 6,

Date 541-715

Filed MAY 7 1941

APR 24 1956

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. 4034

P. O. Address Anderson, 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, fact should be so stated above.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 15103Registration District No. 518Primary Registration District No. 5694

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County McDonald
 (b) City or town McMillin T.P.
 (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 NAMEMary E. Bowman3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex F5. Color or
race W6. (a) Single, widowed, married,
divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if
alive _____ year

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

80324

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 _____

(Burial, cremation, or removal)

(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) Citizen of foreign country _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 17
year _____ hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death Hypostatic
Pneumonia
bronchial

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 sta-
tistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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