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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 374

Primary Registration District No. 6276

Registrar's No. _____

1. PLACE OF DEATH:

(a) County North

(b) City or town Sheridan Mo.
(If outside city or town limits, write "RURAL", and name of township)

(c) Name of hospital or institution: union sup,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 37 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County North

(c) City or town Sheridan Mo.
(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 _____

3. (a) PRINT FULL NAME HUGH BOWEN

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12 year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from May 16 1942 to July 12 1942

that I last saw him alive on July 12 and that death occurred on the date and hour stated above.

4. Sex MO

5. Color or race W

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

6. (b) Name of husband or wife Jane Elizabeth Bowen

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

7. Birth date of deceased July 1852
(Month) (Day) (Year)

Immediate cause of death _____

Duration _____

8. AGE: Years 90 Months 0 Days 16 If less than one day _____ hr _____ min

Due to myocarditis

Due to senile (G.D.)

9. Birthplace Monticello Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Real estate

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

Major findings: Of operations _____

Of autopsy _____

11. Industry or business Farmer

12. Name Hugh Bowen

13. Birthplace Chesler
(City, town, or county) (State or foreign country)

14. Maiden name Pauline

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant _____

(b) Address _____

17. (a) Funeral (b) Date there 7-14-1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheridan Mo.

18. (a) Signature of funeral director Arch C. Dunfee

(b) Address Frank City, Mo.

19. (a) July 20, 1942 (b) Delores Scadden
(Date received local registrar) (Registrar's signature)

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 R. G. Hartman (M. D. or other) 90

Address Sheridan Mo. Date signed 7-10-42

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

MOTHER FATHER

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.....

Arch C. Dwyer

Licensed Embalmer No..... 3252

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, fact should be so stated above.