

FILED **001** **21** **1942**

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Shannon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 David Crockett Bowman

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs. Bowman 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct - 5 - 1870
(Month) (Day) (Year)

8. AGE: Years 71 Months 11 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace Packingham Co Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name David Crockett Bowman
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Bowman
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant John Capeland
(b) Address Shannon MO

17. (a) Burial (b) Date thereof 9-23-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shannon MO

18. (a) Signature of funeral director G. Kuechel
(b) Address Van Buren MO

19. (a) 9-22-42 (b) Frank Boyd MD.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Shannon
(c) City or town Shannon
(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 Sept day 20
year 1942 hour 7 minute 4 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 _____

Due to Central thrombosis

Due to _____

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

Major findings:
Of operations _____

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 Frank Boyd (M. D. or other) _____
Address Shannon MO Date signed 9-22-42

144 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No 5,
District File Number 1042906
Date Filed 10-19-42

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, fact should be so stated above.