

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

21422

Do not use this space.

FILED JUL 12 1943

1. PLACE OF DEATH

(a) County Harrison Registration District No. 136
(b) Township Hamilton Primary Registration District No. 5498 Registered No. 8
(c) City Rural (d) Street No. 1 (If death occurred in Hospital or Institution, write its name instead of street and number) St. 0
(e) Length of residence in city or town where death occurred 60 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

EMILY F BOWEN
(a) Residence, No. Harrison Co., Mo. St. 0 (If nonresident, give city or town and State) 0
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 2 W. widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. M. W. Bowen
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 23 1867
7. AGE YEARS 75 MONTHS 9 DAYS 20 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc. our home
10. Date deceased last worked at this occupation (month and year) 1940 11. Total time (years) spent in this occupation 60

12. BIRTHPLACE (CITY OR TOWN) Albany, Mo. (STATE OR COUNTRY) 0

13. NAME Thos. G. Holloway

14. BIRTHPLACE (CITY OR TOWN) Missouri (STATE OR COUNTRY) 0

15. MAIDEN NAME Celine M. Lee

16. BIRTHPLACE (CITY OR TOWN) Kentucky (STATE OR COUNTRY) 1

17. INFORMANT J. B. Bowen (ADDRESS) Lamar, Ia.

18. BURIAL, CREMATION, OR REMOVAL PLACE Zone Rock, Mo. DATE June 15 1943

19. FUNERAL DIRECTOR (NAME) R. S. White (ADDRESS) Lamar, Ia.

20. FILED 6-15 1943 Chas. Adair Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 13 1943

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive Said to have been 19..... 19..... Death is said to have occurred on the date stated above, at 6 A. m.
The principal cause of death and related causes of importance were as follows:

Tuberculosis of Lungs

Other contributory causes of importance:

Senility. 13 f!

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) Joe Z. Wheeler Colonel
(Address) Betty Mo

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..... *Rollin S. White*

Licensed Embalmer No. *3895*

P. O. Address *Lamoni Iowa*

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.