

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

27249  
3615SEP 7 1943  
Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

## 1. PLACE OF DEATH:

- (a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days  
(Specify whether years, months or days) 19 days

3. (a) PRINT  
FULL NAMERobert Bowman

## 3. (b) If veteran,

name war.

## 3. (c) Social Security

No.

## 4. Sex

Male

## 5. Color or

Race W

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

divorced 0

## 6. (b) Name of husband or wife

## 6. (c) Age of husband or wife if

alive. --- years

## 7. Birth date of deceased

Aug. 2, 1943

(Month)

(Day)

(Year)

## 8. AGE:

Years

Months

Days

If less than one day

19

hr.

min.

## 9. Birthplace

Kansas City  
(City, town, or county)Mo.  
(State or foreign country)

## 10. Usual occupation

## 11. Industry or business

12. Name James H. Bowman13. Birthplace Mo.  
(City, town, or county)0  
(State or foreign country)14. Maiden name Helen Hunt15. Birthplace Mo.  
(City, town, or county)0  
(State or foreign country)16. (a) Informant James H. Bowman(b) Address 2339 Cypress17. (a) Removal

(Burial, cremation, or removal)

(b) Date thereof

Aug. 22, 1943

(Month) (Day) (Year)

(c) Place: burial or cremation Greenfield, Mo.18. (a) Signature of funeral director Shell Funeral Home(b) Address K.C. Mo.19. (a) 8-22-43  
(Date received local registrar)(b) J.C. Brown  
(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2339 Cypress  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21  
year 1943 hour 10 minute 25 A.M.21. I hereby certify that I attended the deceased from  
August 14 1943 to August 21 1943  
that I last saw him alive on August 21 1943  
and that death occurred on the date and hour stated above.  
Immediate cause of death Convulsions  
Etiology unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy See above

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)  
Means of injury 023. Signature Amey R. Thorn (M. D. or other)Address \_\_\_\_\_ Date signed 8-22-43

(Licensed Embalmer's Statement on Reverse Side)

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

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**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.**