

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 10421  
Registrar's No. 281

FILED APR 10 1944

Registration District No. 2

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Goetz Brewing Co. 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 30 yrs  
years, months or days

3. (a) PRINT FULL NAME William Henry Bowman

3. (b) If veteran, name war None 3. (c) Social Security No. 491-10-6923

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Flotilla Florence 6. (c) Age of husband or wife if alive 55 years  
7. Birth date of deceased Dec 2 1880  
(Month) (Day) (Year)

8. AGE: Years 63 Months 3 Days 15 If less than one day  
hr. min.

9. Birthplace Terre Haute, Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Brewer

11. Industry or business Goetz Brewery

12. Name Aaron Bowman

13. Birthplace Terre Haute, Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name Faith Munden

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

16. (a) Informant Mrs W. N. Bowman

(b) Address St Joseph, Mo.

17. (a) Burial (b) Date thereof 3/21/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah, Mo.

18. (a) Signature of funeral director Heater Beale & Bowman

(b) Address 319 So. 10th St Joseph Mo

19. (a) 3/18/44 (b) Rose Helzog  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 114 E Isobell  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 17  
year 1944 hour 9 minute A M.

21. I hereby certify that I attended the deceased from on  
Mar 18th 1944 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 Coronary Thrombosis 1 day  
Due to Angina Pectoris 3 mo.  
94N

Other conditions Man died suddenly  
(Include frequency within 3 months of death)  
while at work on his  
Major findings: regular job. Without  
Of operations any complaint of recent  
Of autopsy no serious illness  
or disability

Underline the cause to which death should be attributed statistically.  
PHYSICIAN \_\_\_\_\_

22. If death was due to external causes, on 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? \_\_\_\_\_

(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury 3

23. Signature H. F. Murphy (M.D. or other) Coroner  
Address 404 So. 3rd St Date signed 3/18/44

(Licensed Embalmer's Statement on Reverse Side)

1233

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

APR 18 1911

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.**