

FILED MAY 8 1944
Registration District No. 7

Primary Registration District No. 4497

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH

(a) County Shelby

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

(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)

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

In this community 40 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 109

(c) City or town Clarence
(If outside city or town limits, write "RURAL") 1

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? Mo (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM M. BOWEN

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18
year 1944 hour 11:30 minute a M.

21. I hereby certify that I attended the deceased from July 7, 1944, to April 18, 1944
that I last saw him alive on April 12, 1944
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
(Day) (Year)

7. Birth date of deceased Feb 6 - 1859
(Month) (Day) (Year)

Immediate cause of death Angina Pectoris
Duration 4 yrs

Due to _____

Due to _____

8. AGE: Years 85 Months 12 Days 12 If less than one day _____ hr. _____ min.

Other conditions senile dementia 6 mos
(Include pregnancy within 3 months of death)

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

10. Usual occupation Farmer

Major findings: 94 lb
Of operations _____
Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Kent Bowen

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

14. Maiden name Lucy Scott

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

16. (a) Informant G. E. Bowen

(b) Address Clarence Mo

17. (a) Burial (b) Date thereof Apr 20
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union

18. (a) Signature of funeral director William R. Phelps

(b) Address Clarence Mo

19. (a) _____ (b) _____
(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 G. L. Hagan (M. D. or other) MD
Address Clarence Mo Date 4/21/44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 5-44-865

Date Filed MAY 5 1944

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.....

W. Hawkins

Licensed Embalmer No. 3498

P. O. Address Shelbina Mo

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.

Registration District No. 337 Primary Registration District No. 4497

1. PLACE OF DEATH:

(a) County Shelby
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Wm M. Bowen

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 W

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

7. Birth date of deceased Feb. 6 1851
(Month) (Day) (Year)

8. AGE: Years 85 Months 2 Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) Ill.

10. Usual occupation _____

11. Industry or business _____

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 12, 44 (b) Madge Good
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 April year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

Miss Mary Cox

Shelburne,

15947