

FILED AUG 8 1944

State File No. ....

Registration District No. 72

Primary Registration District No. 1000

Registrar's No. 790

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(c) Name of hospital or institution: State Hospital No. 2  
(d) Length of stay: In hospital or institution 4 mos. 20 days  
In this community 4 months 20 days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Mercer  
(c) City or town Cainsville  
(d) Street No. ....  
(e) Citizen of foreign country? No.

3. (a) PRINT FULL NAME SAMUEL BOWERS  
(b) If veteran, name war ..... (c) Social Security No. ....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 7 day 23  
year 1944 hour 5 minute A.M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Mary Elaine  
7. Birth date of deceased: 5-7-1878

21. I hereby certify that I attended the deceased from 5-24-1944 to 7-22-1944  
that I last saw him alive on 7-22-1944  
and that death occurred on the date and hour stated above.  
Immediate cause of death: Broncho-pneumonia

8. AGE: Years 66 Months 2 Days 16 If less than one day hr. min.

Due to Meningo-encephalitis Syphilitica  
Duration 10 days

9. Birthplace Mercer County Missouri  
10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death) 30 h

MOTHER FATHER

11. Industry or business Agriculture  
12. Name John Bowers  
13. Birthplace Michigan - Pennsylvania  
14. Maiden name Elizabeth McGinnis  
15. Birthplace Michigan Pennsylvania

Major findings: Of operations .....  
Of autopsy .....  
PHYSICIAN 30 h

16. (a) Informant Wm. H. C. Lake  
(b) Address Cainsville Missouri  
17. (a) Removal Removal (b) Date thereof 7-24-44  
(c) Place: burial or cremation Cainsville Mo  
18. (a) Signature of funeral director Flanagan & Son Inc  
(b) Address St Joseph Mo  
19. (a) 7/24/44 (b) Wm. S. Tinkle

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? .....  
(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 A  
23. Signature J. H. Marroway (M. D. or other) .....  
Address State Hospital No. 2 Date signed 7-23-44

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.....

*Robert H. Gyle*

Licensed Embalmer No. ....

*3308*

P. O. Address: .....

*St. Joseph, 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.