V. S. No. 2
DM—9-4-41
ev. 5-17-39
>I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 21 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30482

Registration District No. 42 Primary Registration District No. 1 Registrar's No. 90

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: State Hospital no. 2.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 43yrs. 2 Mos. 11 days (Specify whether years, months or days)
In this community 43 years, 2 months, 11 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Gentry
(c) City or town Rural.
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME ROBERT B. BOWMAN.
3. (b) If veteran, name war.
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife.
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 7 (Month) 7 (Day) 1871 (Year)

8. AGE: Years 73 Months 9 Days 13. If less than one day hr. min.

9. Birthplace Gentry (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Farming.
11. Industry or business Agriculture
FATHER
12. Name Andrew Bowman
13. Birthplace ? (City, town, or county) Kentucky (State or foreign country)
MOTHER
14. Maiden name ? Long
15. Birthplace ? (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Hospital Records
(b) Address State Hosp. #2 St. Joseph Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-44 (Month) (Day) (Year)
(c) Place: burial or cremation Hospital Cemetery
18. (a) Signature of funeral director Barr Funeral Home
(b) Address 2714 Lafayette St. Joseph Mo.
19. (a) 9/15/44 (Date received local registrar) (b) Leland Eckel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 13 year 1944 hour 5 minute 30 P. M.
21. I hereby certify that I attended the deceased from 3-15-, 1944 to 9-13-, 1944 that I last saw him alive on 9-13-, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis	15 years
Due to: Arteriosclerosis	25 years
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. H. Morroway (M. D. or other)
Address State Hospital No. 2 Date signed 9/13/44.

1377 (Licensed Embalmer's Statement on Reverse Side)

Was not embalmed

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.