

FILED NOV 14 1944

Registration District No. 297

Primary Registration District No. 6021

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Hope Grove Twp.
(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
In this community all his life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 89
(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 _____

3. (a) PRINT FULL NAME David 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 married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan. 23 - 1859
(Month) (Day) (Year)

8. AGE: Years 85 Months 8 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace Ray Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name David B. Bowman
13. Birthplace Rockingham Va.
(City, town, or county) (State or foreign country)
14. Maiden name Anna Shoverlin
15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Jim D Bowman
(b) Address Norborne Mo

17. (a) Buried (b) Date thereof Oct 9 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walden Cem

18. (a) Signature of funeral director John W. Knipchen

(b) Address Harlem Mo

19. (a) 10-9-1944 (b) Miss Charles Lippert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6
year 1944 hour 9 minute 20 A.M.

21. I hereby certify that I attended the deceased from 1940 to Oct 6 1944
that I last saw him alive on Sept 28 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Due to Chronic Int. Nephritis
Hypertension
Due to Arterio Sclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 3/10
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 Carl Reed (M. D. certificate)
Address Harlem Mo. Date signed 10-7-44

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 11-13-44

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 me

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed John W. Knipschild

Licensed Embalmer No. 2789

P. O. Address Hardin, 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.