

FILED DEC 11 1944

State File No. _____

Registration District No. _____

Primary Registration District No. 4097

Registrar's No. 179

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Harrisonville
(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 JOHN H. 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 Widowed
6. (b) Name of husband or wife Luella L. Bowman 6. (c) Age of husband or wife if alive ✓ years 18 55
7. Birth date of deceased Feb (Month) (Day) (Year)

8. AGE: Years 89 Months 9 Days 4 If less than one day hr. min.

9. Birthplace Bates Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Boston Bowman
13. Birthplace Cincinnati Ohio (City, town, or county) (State or foreign country)
14. Maiden name Sarah Raper
15. Birthplace Mo Carolina (City, town, or county) (State or foreign country)

16. (a) Informant A. B. Bowman
(b) Address Harrisonville Mo

17. (a) burial (b) Date thereof 12-1-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crematorium - adrian Mo

18. (a) Signature of funeral director RUNNENBURGER'S
(b) Address HARRISONVILLE, MO

19. (a) Dec. 1, 1944 (b) Margaret Volle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass 19
(c) City or town Harrisonville 1
(If outside city or town limits, write "RURAL") 0
(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 Nov day 29
year 1944 hour 1:15 minute 4 M.

21. I hereby certify that I attended the deceased from Nov. 23
1944 to Nov. 29 1944,
that I last saw him alive on Nov. 29 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
with degeneration Duration 1 yr. 6 mos.

Due to _____
Due to Chronic Nephritis 3 yrs.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None 12/1/44
Of autopsy none 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) (a) Means of injury ✓

23. Signature Dr. E. H. Owen (M. D. or other) Dr.
Address Harrisonville Mo Date signed 11/30/44

STATE OF H. MAINE

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.....

Ernest McQuinnburger

Licensed Embalmer No.

3368

P. O. Address.....

Harrisonville 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Dec

Registration District No.

59

Primary Registration District No.

4097

Registrar's No.

129

1. PLACE OF DEATH:

- (a) County Cass
(b) City or town Harrisonville
(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 NAMEJohn H. Bowman

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

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 25 years

7. Birth date of deceased Feb 25 1925
(Month) (Day) (Year)

8. AGE: Years 89 Months 9 Days 1 If less than one day, min.

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

10. Usual occupation Merchant
11. Industry or business Retired Merchant

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

- (c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) Margaret Volle (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 Nov day 21 year 1925 minute 19 M.

21. I hereby certify that I attended the deceased from 1925 to 1925 that I last saw him alive on 1925 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 sta-
tistically.

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

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