

S. No. 2
M-5-43
7-17-39
P 1 X36671

State File No.

Registrar's No.

FILED SEP 20 1945

Registration District No.

Primary Registration District No. 3043

239

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

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: LEVERING HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Roy F. Bowers

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 Etta

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

7. Birth date of deceased Feb 16 1892
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>5</u>	<u>22</u>	hr. min.

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

10. Usual occupation operated Restaurants

11. Industry or business _____

MOTHER FATHER

12. Name Zilotas Bowers

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

14. Maiden name FANNIE Bowers, Ashley

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

16. (a) Informant Mrs Etta Bower

(b) Address Hannibal

17. (a) Burial (b) Date thereof 8-9-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation M. OLIVIER CEMETERY

18. (a) Signature of funeral director JAMES O'DONNELL

(b) Address Hannibal, Mo.

19. (a) 8/20/45 (b) D. E. M. Lucke
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 64

(c) City or town Hannibal ?
(If outside city or town limits, write "RURAL")

(d) Street No. 491 JEFFERSON ST. 4
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 7 year 1945 hour 9 minute 55 A.M.

21. I hereby certify that I attended the deceased from Aug 4, 1945, to Aug 7, 1945
that I last saw h. live on Aug 7, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to diabetes mellitus

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 W. J. ... (M. D. or other) _____

Address Hannibal Date signed _____

Duration

?

?

PHYSICIAN

Underline the cause to which death should be charged statistically.

Aug 7-45

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.....

James Daniel

Licensed Embalmer No.....

2092

P. O. Address.....

Hannibal 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.