

FILED JUL 11 1946

State File No. _____

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 207

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Hospital No. 4 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr. 3 mos. 24 das.
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Phelps 94
(c) City or town St. James 1
(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 CELIA OPHELIA BOWEN

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

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cecil Bowen - 2nd. 6. (c) Age of husband or wife if alive _____ years Age Unk.

7. Birth date of deceased January 25, 1901
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>4</u>	<u>5</u>	_____ hr. _____ min.

9. Birthplace Alabama 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John D. Patterson 7

13. Birthplace Unknown 7
(City, town, or county) (State or foreign country)

14. Maiden name Ella Barber

15. Birthplace Unknown 7
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 6-2-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Adams Cem., St. James, Mo.

18. (a) Signature of funeral director Licklider Funeral Home

(b) Address St. James, Missouri

19. (a) 6-21-46 (b) Ether Rudloff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30
year 1946 hour 1 minute 05 P. M.

21. I hereby certify that I attended the deceased from May 6, 1946 19____ to May 30, 1946 19____;
that I last saw her alive on May 30, 1946 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration _____

Due to _____
Due to Paralysis

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

Major findings: gpa
Of operations _____
Of autopsy No autopsy. PHYSICIAN _____

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) (e) Means of injury _____

23. Signature George W. Reuss (M. D. or other) MD
Address Farmington, Mo Date signed 6-1-46

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

RECEIVED

District Health Officer No. 4
District No. 246-2358
Date Recd. 7-10-46

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 Ben J. Miller
Licensed Embalmer No. 3752
P. O. Address Farmington, 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.