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X35897

FILED FEB 5 1947

Registration District No. 218

Primary Registration District No. 2986024

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Rural Lawson's Pk
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray 84

(c) City or town Rural Pocke 1
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 1

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME COLONA ANN BOWERS

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

20. DATE OF DEATH: Month Dec. day 13
year 1946 hour 12 minute 10 P. M.

21. I hereby certify that I attended the deceased from Nov. 20 1946, to Dec. 13 1946,
that I last saw her alive on Dec. 8 1946
and that death occurred on the date and hour stated above.

4. Sex F / 5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Joe Bowers 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased: Feb (Month) 10 (Day) 1870 (Year)

Immediate cause of death Myocardial Failure Duration 3 days

Due to Senile cardio-renal disease

Due to _____

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

8. AGE: Years Months Days If less than one day
76 10 3 hr. _____ min.

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

Major findings: Of operations _____

Of autopsy 1517

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation _____

11. Industry or business Housewife

12. Name Harrison Bleninger

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

14. Maiden name Nancy Lites

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

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 1

23. Signature Arthur D. Buehler (M. D. or other) 1
Address Lawson Date signed Dec 14, 1946

16. (a) Informant Orbel Bowers

(b) Address Lawson Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15 46 (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director Jarman Prichard

(b) Address Lawson Mo.

19. (a) Dec 15 1946 (Date received local registrar) (b) Mrs. Raymond Krove (Registrar's signature)

204

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

RECEIVED

District Health Officer No. B1

District File Number.....

Date Filed 1-25-47

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 E. E. White

Licensed Embalmer No. 4168

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.

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-3-45
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Felt
Registrar's No. 23

Registration District No. 298 Primary Registration District No. 6024

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Rural
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Colona A. Bauer

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Feb 10 1910
(Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mrs. Raymond Moore (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 April Day 12 year 1949 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; 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 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) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

S-43630