

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 7 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14360

State File No. _____

Registration District No. 243

Primary Registration District No. 4364

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Stella, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Cardwell Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME Samuel Franklin Bowman

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 16 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 7 8 _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business Oliver Bowman

12. Name Oliver Bowman

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

14. Maiden name Sarah Wagoner

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

16. (a) Informant Grover C. Bowman

(b) Address Fairview, Mo.

17. (a) Burial (b) Date thereof 4/27/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Macedonia Cem Stella, Mo.

18. (a) Signature of funeral director W. M. Davis

(b) Address Wheaton, Mo.

19. (a) May 2 1947 (b) Alpha Dyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Fairview, Mo. R#
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 25
year _____ hour 7:00 minute 30 M.

21. I hereby certify that I attended the deceased from: 4-20-47 to 4-24-47
that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia Duration 8 days

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? _____

(Specify type of place) While at work _____ (Specify type of injury) _____

23. Signature Alpha Dyer (M. D. or other) _____
Address Stella, Mo. Date signed 4/27/47

RECEIVED

District Health Officer No. *Newton*
District File Number *547-87*
Date filed *5-5-47*

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 *Wm. Martin Byrne*

Licensed Embalmer No. *3442*

P. O. Address *Wheaton, 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.