

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17983

FILED JUN 6 1947

Registration District No. 283

Primary Registration District No. 5655

Registrar's No. 75

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Mt. Vernon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 157 days
(Specify whether
In this community 157 Days
years, months or days)

3. (a) PRINT FULL NAME Thomas Lincoln Bowman

3. (b) If veteran, name war No 3. (c) Social Security No. 492-14-3740

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years
7. Birth date of deceased Dec. 5 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 5 11 hr. min.

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

10. Usual occupation Common labor

11. Industry or business

12. Name Joe E. Bowman
13. Birthplace Ray County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Amanda Summers
15. Birthplace Unknown Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant E. McMichael, Record Clerk
(b) Address Mo. State San. Mt. Vernon, Mo.

17. (a) Removal (b) Date thereof 5-16-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richmond, Mo.

18. (c) Signature of funeral director Geo. B. Cox

(b) Address Richmond, Mo.

19. (a) 5/24/47 (b) CP Helbrick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray
(c) City or town 429 So. Camden, Richmond, Mo
(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 May day 16
year 1947 hour 1:45 minute A.M.

21. I hereby certify that I attended the deceased from Dec 10 19 46 to May 16 19 47
that I last saw him alive on May 16 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death
Far Advanced Pulmonary Tbc. Duration 3 1/2 Yrs.

Due to _____

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) Means of injury _____

23. Signature J. W. Dileman (M. D. or other) M. D.
Address Mount Vernon, Mo Date signed 5-16-47

RECEIVED
District Health Officer No. 6,
District File Number 647-599
Date Filed JUN 4 1947

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..... *Geo. B. Over*

Licensed Embalmer No. *946*

P. O. Address *Ma Ternon 7th*

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.