

FILED JUL 14 1947

Registration District No. 1

Primary Registration District No. 3015

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Clinton
(b) City or town Cameron
(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 six years
years, months or days

8. (a) PRINT FULL NAME Bowman Jessie

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

4. Sex female 5. Color or race white 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 July (Month) 4 (Day) 1870 (Year)

8. AGE: 76 Years 11 Months 27 Days If less than one day hr. _____ min. _____

9. Birthplace: Osterdick (City, town, or county) Iowa (State or foreign country)

10. Usual occupation Teacher

11. Industry or business School

12. Name Jasper N. Bowman

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

14. Maiden name Martha Farrow

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

16. (a) Informant Jasper F. Bowman

(b) Address Cameron MO.

17. (a) _____ (b) Date thereof July 3 '47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lenox Iowa

18. (a) Signature of funeral director DEMOSSE CRUNK

(b) Address CLINTON MO.

19. (a) July 2, 1947 (b) Winifred W. Moxon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLINTON

(c) City or town CAMERON
(If outside city or town limits write "RURAL")

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

(e) If foreign born, how long in U. S. A. ? NO. years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1
year 1947 hour 6.00 minute 45 M.

21. I hereby certify that I attended the deceased from June 3
_____, 1946, to June 28, 1947

that I last saw her alive on June 28, 1947

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral hemorrhage Duration 2 days

Due to Generalized + Cerebral

Due to arteriosclerosis

Senility

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

Address Cameron, Mo. Date signed 2 July 1947

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

.....
working under my personal supervision.

Signed....., Registered Apprentice No.....
Lee Moss Grent

Licensed Embalmer No. *2533*

P. O. Address *Cameron, 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, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 460

Registration District No. 75

Primary Registration District No. 3015

1. PLACE OF DEATH:

(a) County Clinton
(b) City or town Camers
(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 years, months or days)

3. (a) PRINT
FULL NAME

3. (b) If veteran,
name war

(c) Social Security
No.

4. Sex M 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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days
76 4 2
If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) Winifred W. Mores (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 July Year 1947 Hour 4 minute 1 M.

21. I hereby certify that I attended the deceased from 1947 to 1947,
that I last saw him alive on July 1, 1947,
and that death occurred on the date and hour stated above.
Immediate cause of death

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 sta-
tistically.

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) (c) Means of injury

23. Signature (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

S-20376