

FILED AUG 12 1947

Registration District No. 3

Primary Registration District No. 3010

Registrar's No. 236

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

1. PLACE OF DEATH:  
 (a) County Cape Girardeau  
 (b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: S. E. Mo. Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Cape Girardeau  
 (c) City or town Rural  
(Outside city or town limits, write "RURAL")  
 (d) Street No. Oak Ridge Mo R#1  
(If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Corydon Sue Bowers  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 29  
 year 1947 hour 4:30 minute A. M.  
 21. I hereby certify that I attended the deceased from July 27, 1947, to July 29, 1947, that I last saw her alive on July 29, 1947, and that death occurred on the date and hour stated above.

4. Sex ♀ 5. Color or race W  
 6. (a) Single, widowed, married, divorced Child  
 6. (c) Age of husband or wife: alive years \_\_\_\_\_  
 7. Birth date of deceased: June (Month) 2 (Day) 1946 (Year)

Immediate cause of death: Meningitis, tuberculous Duration 3 wks.  
 Due to was in direct contact w mother who had active TB for 2 1/2 yrs. mor. 5 yrs. mother died w/ tuberculous w/ abscessed.  
 Due to \_\_\_\_\_  
 Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years 1 Months 0 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace: Oak Ridge Mo (City, town, or county) \_\_\_\_\_ (State or foreign country)  
 10. Usual occupation: Child

Major findings: nil  
 Of operations: nil  
 Of autopsy: nil  
 PHYSICIAN: \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER  
 11. Industry or business \_\_\_\_\_  
 12. Name Ora Bowers  
 13. Birthplace Oak Ridge Mo (City, town, or county) \_\_\_\_\_ (State or foreign country)  
 14. Maiden name Louise Sahr  
 15. Birthplace Oak Ridge Mo (City, town, or county) \_\_\_\_\_ (State or foreign country)  
 16. (a) Informant Ora Bowers  
 (b) Address Cape Girardeau Mo  
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/47  
(Month) (Day) (Year)  
 (c) Place: burial or cremation: Old Salem Church  
 18. (a) Signature of funeral director: M. C. Cornish  
 (b) Address Jackson Mo  
 19. (a) 8-751947 (Date received local registrar) (b) G. C. Simmons (Registrar's signature) 1122

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 6  
 23. Signature Chas. J. Derber (M. D. or Other) \_\_\_\_\_  
 Address Cape Girardeau Mo Date signed 7/30/47

Health Officer No. 4  
File Number 847-1041  
8-11-47

**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.....

Not Embalmed, Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.**