

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED APR 26 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11532
Registrar's No. 434

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County BUCHANAN
(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
424 S. 20TH ST. 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 9 mo.
years, months or days

3. (a) PRINT FULL NAME ZENA E. BOWMAN

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

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife GEORGE L. BOWMAN 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MARCH 4 - 1866
(Month) (Day) (Year)

8. AGE: Years 82 Months 1 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace LAWRENCE Co. MO. G
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business HOME

12. Name E. H. PRUITT

13. Birthplace ADEN CO. KY.
(City, town, or county) (State or foreign country)

14. Maiden name ARLINE BUTTON MORRIS

15. Birthplace BARON CO. KY.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. N. Martin

(b) Address 424 S. 20th St. Joseph Mo.

17. (a) BURIAL (b) Date thereof APR 18, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HAWKEYE CEM.

18. (a) Signature of funeral director Shawn E. Kent & Son

(b) Address Shawn City, Mo.

19. (a) 4-19-48 (b) E. L. Perkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County SULLIVAN 105
(c) City or town GREEN CITY
(If outside city or town limits, write "RURAL")
(d) Street No. " (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15th.
year 1948 hour 7P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Mar. 1, 1948, 19____, to Apr. 15, 1948, 19____;
that I last saw her alive on April, 15, 1948, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 2 days

Due to H.B.P. & Mitral Insufficiency

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) (c) Means of injury Q

23. Signature J. R. Elliott (M. D. not M. D.)

Address 801 1/2 Francis St. Joseph Mo. signed 4/14/48

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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 Archie W. Wade.....

Licensed Embalmer No. 3037.....

P. O. Address. Green City, 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.