

Registration District No. **47**

Primary Registration District No. **3008**

1. PLACE OF DEATH:
(a) County **Callaway**
(b) City or town **Fulton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Callaway County Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days** (Specify whether
In this community **2 months** (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Callaway**
(c) City or town **Fulton (Rural)**
(If outside city or town limits, write "RURAL")
R.F.D. # 5
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Charles Arthur BOWEN**

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

4. Sex **Male** 5. Color **white** 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 **March 2, 1948**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	5	17	hr. _____ min. _____

9. Birthplace **Frankfort, Indiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business _____

12. Name **Frank Bowen**

13. Birthplace **Frankfort, Indiana**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Jones**

15. Birthplace **Frankfort, Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Frank Bowen**
(b) Address **R.F.D. # 5 Fulton, Mo.**

17. (a) **Burial** (b) Date thereof **8/20/48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Hillcrest**

18. (a) Signature of funeral director **Glen Y. Mangin**
(b) Address **712 Court St., Fulton, Mo.**

19. (a) **8-20-1948** (b) **Jesse Mangin**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **19**
year **1948** hour **2** minute **45** A.-M.

21. I hereby certify that I attended the deceased from **8/17** 1948 to **8/19** 1948
that I last saw him alive on **8/18** 1948
and that death occurred on the date and hour stated above.

Immediate cause of death **Ac. Peritonitis**
Duration **several days**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **none**
Of autopsy **none**

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 **MD**
Signature **Henry Duest** (M. D. or other) **MD**
Address **Fulton, Mo.** Date signed **8/20/48**

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

2
41
39
26390

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed AUG 24 1946

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 *Theodore Skinner, Jr.*
Licensed Embalmer No. *45-56*
P. O. Address *Fulton, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.