

FILED SEP 25 1948

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30725

Registration District No. 318

Primary Registration District No. 3058

Registrar's No. 183

1. PLACE OF DEATH:

(a) County ST CHARLES
(b) City or town ST CHARLES
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST JOSEPH'S
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME SHARON K BOWMAN

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

4. Sex F 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 _____ years
7. Birth date of deceased DEC SEPT 11 1948
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 1 If less than one day 12 hr. _____ min.

9. Birthplace ST CHARLES MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation NIL

11. Industry or business NIL

12. Name FLOYD BOWMAN

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

14. Maiden name Alice M. Bates

15. Birthplace St. Charles Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant FLOYD BOWMAN

(b) Address 9330 LATROPE

17. (a) BURIAL (b) Date thereof SEPT 14 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LAUREL HILL GARDENS

18. (a) Signature of funeral director DAUMANN BROTHERS INC

(b) Address 1504 WOODSON RD. OVERLAND

19. (a) 9-14-48 (b) Jennie Hamilton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST LOUIS
(c) City or town OVERLAND
(If outside city or town limits, write "RURAL")
(d) Street No. 9330 LATROPE
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 13
year 1948 hour 7:35 minute A. M.

21. I hereby certify that I attended the deceased from 9-11-48
_____, 19____, to 9-12-48, 19____;
that I last saw her alive on 9-12-48, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
atalectasis from aspiration
of foreign body
Due to aspiration of foreign body
Due to _____

Other conditions (Include pregnancy within 3 months of death) 16.10

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)
(e) Means of injury _____

23. Signature J. L. Smith (M. D. or other) MD

Address St Charles Mo Date signed 9-13-48

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

MOTHER FATHER

RECEIVED
DISTRICT HEALTH OFFICER No. 9,
SEP 23 1948
Date of

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. act
Registrar's No. 183

Registration District No. 318 Primary Registration District No. 3058

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles
(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

Sharon K. Bowman

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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 (If less than one day hr. min.)

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

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) Sept 14 - 48 (b) Frankie Hammett (Registrar's signature)
(Date received local registrar)

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 Sept year 1948 hour 1 minute 13 M.

21. I hereby certify that I attended the deceased from 1948 to 1948, that I last saw him alive on Sept 14 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

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 (M. D. or other)

Date signed

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-30725