

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. FILED FEB 11 1954 REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **3007**

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY DUNKLIN	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN POPLAR BLUFF		c. LENGTH OF STAY (in this place) 11 days	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CLARKTON		d. STREET ADDRESS (If rural, give location) NONE	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) ROBERT	b. (Middle) L.		c. (Last) BOWDEN		Jan 25, 1954
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARCH 4, 1892	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER	10b. KIND OF BUSINESS OR INDUSTRY BARBERING	11. BIRTHPLACE (State or foreign country) HENRY CO., TENN.		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME BOB BOWDEN		13b. MOTHER'S MAIDEN NAME ADA COX		14. NAME OF HUSBAND OR WIFE CLAUDIE BOWDEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY OCCLUSION			INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

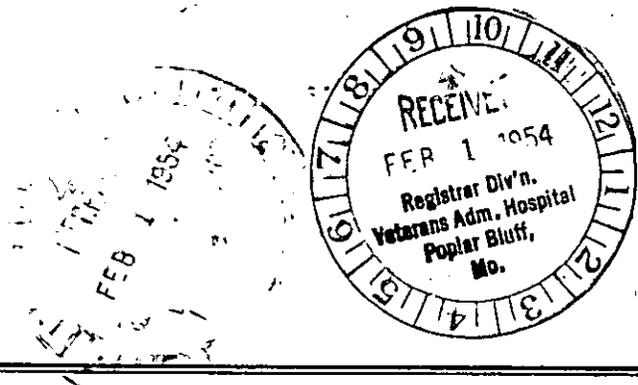
22. I hereby certify that I attended the deceased from **Jan. 14, 1954**, to **Jan. 25, 1954**, and that death occurred at **11:50 Am.**, from the causes and on the date stated above.

23a. SIGNATURE E. B. BASKETT, M.D.		23b. ADDRESS VA HOSPITAL, POPLAR BLUFF, MO.		23c. DATE SIGNED 1-25-54	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Jan. 27, 1954		24c. NAME OF CEMETERY OR CREMATORY Stanfield	
24d. LOCATION (City, town, or county) (State) near Clarkton, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Lloyd Russell, Piggott Ark			
DATE REC'D BY LOCAL REG. 2/3/54		REGISTRAR'S SIGNATURE R. W. Shurtell		ADDRESS	

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

RECEIVED
FEB 8 1954
BUTLER CO. HEALTH CENTER
FILE No. _____

NOV 14 1961



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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Clayd Russell

Licensed Embalmer No. 509- Ark

P. O. Address Jiggott Ark

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.