

FILED JUL 30 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25929

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 100	
1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SIKESTON</u>		c. LENGTH OF STAY (in this place) <u>LIFE</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SIKESTON</u>		10030	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>214 N. SCOTT</u>				d. STREET ADDRESS (If rural, give location) <u>214 N. SCOTT</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>HITA</u>		b. (Middle) <u>GILBREATH</u>		c. (Last) <u>BOWMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7-15-54</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>7-2-1887</u>	
9. AGE (in years last birthday) <u>67</u>		10. AGE (in years last birthday) <u>67</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>SIKESTON MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		13a. FATHER'S NAME <u>JOHN GILBREATH</u>		13b. MOTHER'S MAIDEN NAME <u>—</u>	
13c. NAME OF HUSBAND OR WIFE <u>LYMAN R.</u>		14. NAME OF HUSBAND OR WIFE <u>LYMAN R.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Lyman R Bowman - Sikeston Mo</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Lyman R Bowman - Sikeston Mo</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Lyman R Bowman - Sikeston Mo</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Lyman R Bowman - Sikeston Mo</u>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculosis Cardiovascular disease</u> 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 _____				INTERVAL BETWEEN ONSET AND DEATH <u>104 years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>443X</u>		20. AUTOPSY? YES ☐ NO ☒		20. AUTOPSY? YES ☐ NO ☒	
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) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? _____		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>Feb. 15, 1952</u> , to <u>June 3, 1954</u> , that I last saw the deceased alive on <u>June 3, 1954</u> , and that death occurred at <u>5:10 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Shannon C. McCreary Jr.</u>		23b. ADDRESS <u>Sikeston</u>		23c. DATE SIGNED <u>7/19/54</u>		23c. DATE SIGNED <u>7/19/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>7-17-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>GARDEN OF MEMORIES</u>		24d. LOCATION (City, town, or county) (State) <u>SIKESTON MO</u>	
DATE REC'D BY LOCAL REG. <u>7-22-54</u>		REGISTRAR'S SIGNATURE <u>Mrs. Clara Hunter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Welsh Funeral Home - Sikeston Mo</u>		ADDRESS <u>—</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

DATE RECEIVED JUL 26 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No. 754-147

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

Raymond C. Lewis

Licensed Embalmer No. 3467

P. O. Address Sebaston 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.