

FILED NOV 8 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33040

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1149

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>50 years</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. CITY OR TOWN <u>St. Joseph</u>		e. STREET ADDRESS (If rural, give location) <u>701 S. 17th St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wells Nuring Home</u> <u>701 S. 17th St.</u>			

3. NAME OF DECEASED (Type or Print) <u>Walter R. Bowling</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>October 30, 1954</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>December 8, 1884</u>	9. AGE (In years last birthday) <u>69</u> Months _____ Days _____	IF UNDER 1 YEAR Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. switchman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>railroad</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Spring City, Tennessee</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>John Newton Bowling</u>	13b. MOTHER'S MAIDEN NAME <u>Lily Spangler</u>	14. NAME OF HUSBAND OR WIFE <u>Atha</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Dale O. Bowling, Columbia, Mo.</u>	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinomatosis</u>		<u>3 mos.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of urinary bladder</u> DUE TO (c)		<u>3 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arteriosclerosis 10 yrs.</u>			

19a. DATE OF OPERATION <u>Several in Sept.</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of urinary bladder</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 11-12, 1952 to Oct. 29, 1954, that I last saw the deceased alive on 10-29, 1954, and that death occurred at 12:30a m., from the causes and on the date stated above.

23a. SIGNATURE <u>Gordon Sawyer, M.D.</u>	(Name or title)	23b. ADDRESS <u>902 Edmund H. Joyce</u>	23c. DATE SIGNED <u>11/1/54</u>
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24a. BURIAL, CREMATION, REMOVAL, OR PLACEMENT (Specify) <u>burial</u>	24b. DATE <u>11/1/1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Nov 4, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	485-0	25. FUNERAL DIRECTOR'S SIGNATURE <u>Heston - Bowman - St. Joseph, Mo.</u>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 11 1955

*W. Spalding*

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 Billie C. Gordon, Student Embalmer No. 571 working under my personal supervision.

Student Billie C. Gordon  
Signature of Student Embalmer

Signed William Spalding  
Licensed Embalmer No. 4535

P. O. Address St. Joseph

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.