

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43231**

BIRTH NO. _____ REG. DIST. NO. **71** PRIMARY REG. DIST. NO. **3012** Registrar's No. **139**

1. PLACE OF DEATH a. COUNTY CLAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY CLAY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN EXCELSIOR SPRINGS		c. CITY OR TOWN EXCELSIOR SPRINGS	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> 6002	
d. FULL NAME OF HOSPITAL OR INSTITUTION 109 SARATOGA		No. STREET ADDRESS (If rural, give location) 109 SARATOGA	

3. NAME OF DECEASED (Type or Print) a. (First) JESSE b. (Middle) C. c. (Last) BOWMAN			4. DATE OF DEATH (Month) (Day) (Year) DEC. 31 1954		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH JAN. 22, 1882		9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months Days	
IF UNDER 1 YEAR Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED VETERINARIAN		10b. KIND OF BUSINESS OR INDUSTRY D.V.M.	
11. BIRTHPLACE (City and State or Foreign Country) KANSAS			12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME SAMUEL BOWMAN		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE ANNA R. BOWMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS ANNA R. BOWMAN 109 SARATOGA EX. SPRINGS, MO.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion		DUE TO (b) Hypertension		instant	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) arteriosclerosis			
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		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) (Min.)		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 **12/21/52**, 19**52**, to **12/31**, 19**54** that I last saw the deceased alive on **12/31/54**, and that death occurred at **11:50**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. D. Excelsior Springs, Mo.		23b. ADDRESS		23c. DATE SIGNED 12/31/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 1-2-55		24c. NAME OF CEMETERY OR CREMATORY TECUMSEH QEM.		24d. LOCATION (City, town, or county) (State) TECUMSEH, NEBRASKA	
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DATE REC'D BY LOCAL REG. 1-3-54		REGISTRAR'S SIGNATURE Caroline Hutchings		FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Charles Prichard, Excelsior Springs, Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4001
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.