

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23874  
STATE FILE NUMBER

FILED JUL 26 1957

Registration District No. 65 Primary Registration District No. 3250 Registrar's No. \_\_\_\_\_

|   |                               |   |   |   |  |
|---|-------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>CHARITON</u>  |                               |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>CHARITON</u> |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BRUNSWICK</u> <del>FEAR</del>  |                               | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <u>BRUNSWICK</u>  |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                              |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>UNDERWOOD NURSING</u>  |                               | Length of stay in 1b <u>4 years</u>   | d. STREET ADDRESS (If outside, give location)   |   | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                             |
| 3. NAME OF DECEASED (Type or print) <u>ABBIE</u>  |                               |   | First Middle Last <u>BOWERSMITH</u>   |   | 4. DATE OF DEATH <u>JULY 20 1957</u>   |
| 5. SEX <u>FEMALE</u>  | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL 12, 1864</u>  | 9. AGE (In years last birthday) <u>93</u> | IF UNDER 1 YEAR Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>  | 11. BIRTHPLACE (City and state or country) <u>DANVILLE MISSOURI</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |
| 13. FATHER'S NAME <u>DANIEL S. JASPER</u>   |                               |   | 14. MOTHER'S MAIDEN NAME <u>ADIE MAGRUDER</u>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>N/D</u>  |                               | 16. SOCIAL SECURITY NO. <u>NONE</u>   | 17. INFORMANT <u>MRS. E. F. SCHULTZ, ENID, OKLAHOMA</u>   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage Thrombosis</u>  |                               |   |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |                               |   |   |   |  |
| DUE TO (b) <u>Arteriovascular disease</u>   |                               |   |   |   | <u>10 years</u>  |
| DUE TO (c) <u>Senile debility</u>   |                               |   |   |   | <u>15 years</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>   |                               |   |   |   | 19. WAS AUTOPSY PERFORMED? <u>331 X</u><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY<br>Hour _____ Month _____ Day _____ Year _____<br>a. m. _____ p. m. _____   |                               |   |   |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                               | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |  |
| 21. I attended the deceased from <u>August 15-48</u> to <u>July 20-57</u> and last saw her alive on <u>July 20-1957</u><br>Death occurred at <u>11440a</u> on the date stated above; and to the best of my knowledge, from the causes stated. |                               |   |   |   |  |
| 22a. SIGNATURE <u>Traver C. Rice M.D.</u>   |                               | 22b. ADDRESS <u>Brunswick, Mo.</u>  |   | 22c. DATE SIGNED <u>July 23-57</u>        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                               | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY        |  |
| <u>Burial</u>   |                               | <u>July 27, 1957</u>  |   | <u>ELLIOTT GROVE</u>                      |  |
| 24. FUNERAL DIRECTOR  |                               | 25. DATE RECD. BY LOCAL REG.  |   | 26. REGISTRAR'S SIGNATURE                 |  |
| <u>Heisel Funeral Home, Brunswick, Mo.</u>  |                               | <u>7-26-57</u>  |   | <u>Tom Dundon Acting Dir.</u>             |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, or other person certifying to a death due to natural causes. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related.

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.....  
*William R. Koz...*

Licensed Embalmer No. *47*

P. O. Address *Brunswick*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.