

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008634

STATE FILE NUMBER

FILED MAR 10 1958

Registration District No. 5

Primary Registration District No. 6288

Registrar's No. 375

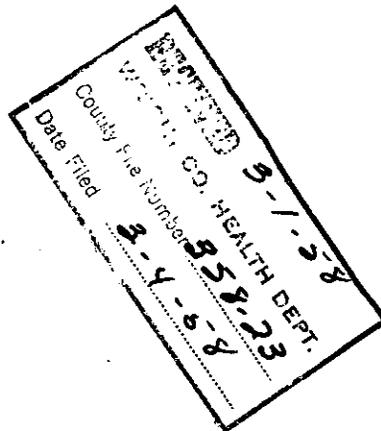
1. PLACE OF DEATH a. COUNTY <u>WRIGHT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WRIGHT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>UNION</u>		c. CITY OR TOWN <u>NIANGUA STAR RT</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>9 MIE NIANGUA</u>	
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle Last <u>BOWDEN</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>24</u> Year <u>1958</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 type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 6 1885</u>
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	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>
13a. FATHER'S NAME <u>JACKSON LETTERMAN</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET TWENKLE</u>	14. NAME OF HUSBAND OR WIFE <u>JOHN F.</u>
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.	17. INFORMANT <u>JOHN BOWDEN NIANGUA STAR RT</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCULATORY FAILURE</u> DUE TO (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>331X</u>
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 Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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>1-31-58</u> to <u>2-24-58</u> and last saw her alive on <u>2-22-58</u> Death occurred at <u>3:00 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. Blinn, D.D. 2</u>		22b. ADDRESS <u>Manassett, Mo.</u>	22c. DATE SIGNED <u>2/25/58</u>
23a. BURIAL, CREATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-26-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NIANGUA</u>	23d. LOCATION (City, town, or county) (State) <u>NIANGUA MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>BARBER-EDWARDS MARSHFIELD</u>		25. DATE RECD. BY LOCAL REG. <u>2-2-58</u>	26. REGISTRAR'S SIGNATURE <u>Louise J. Jones</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally 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 *Rev. Barber* .....

Licensed Embalmer No. *384*  
P. O. Address *Wm. Grove Wisc.*

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.