

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

89-000253

STATE FILE NUMBER

FILED FEB 2 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 98

300
 1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Andrew	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN Amazonia	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hosp.		d. STREET ADDRESS (If outside, give location) R. R. #1	
3. NAME OF DECEASED (Type or print) First DAVID Middle WARNER Last BOWMAN		4. DATE OF DEATH Month Jan. Day 26 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Warner I. Bowman		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT Mr. Ira Bowman R. R. #1, Amazonia, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart disease atelectasis, congenital Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7545			INTERVAL BETWEEN ONSET AND DEATH
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.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) St. Joseph Buch. Mo	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION St. Joseph Buch. Mo	
21. I attended the deceased from Death occurred at 1-18-59 5:35 a.m.		and last saw her alive on 1-25-59 him	
22a. SIGNATURE H. E. Petersen		22b. ADDRESS St. Joseph Mo	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	
23b. DATE 1/28/1959		23d. LOCATION (City, town, or county) (State) Amazonia, Missouri	
24. FUNERAL DIRECTOR Heston-Bowman		25. DATE RECD. BY LOCAL REG. Jan 27, 1959	
ADDRESS St. Joseph, Mo.		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell	

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diagnoses in Part I must be causally related.

Dr. H. E. Petersen

W. Peterson

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 Gulberg*

Licensed Embalmer No. *4535*
P. O. Address *St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.