

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

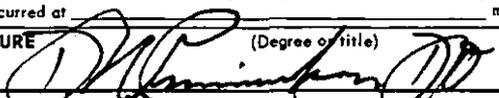
59-018259

STATE FILE NUMBER

8
FILED MAY 19 1959

Registration District No. 167 Primary Registration District No. 4256 Registrar's No. 19

300
-57
0

1. PLACE OF DEATH a. COUNTY Johnson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Holden		c. CITY OR TOWN Greenwood	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Holden Hospital		d. STREET ADDRESS Town	
3. NAME OF DECEASED (Type or print) First CORA Middle JEANETTE Last BOWIN		4. DATE OF DEATH May 7, 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Greenwood, Mo.
13a. FATHER'S NAME James Sample		13b. MOTHER'S MAIDEN NAME Mary Jane Boyer	14. NAME OF HUSBAND OR WIFE James Bowin (Dec)
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 Address Earl Bowin, Greenwood, 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) Hypostatic Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Fractured Rt. Hip DUE TO (c) Senile Psychosis			INTERVAL BETWEEN ONSET AND DEATH 3 days 4 days 6 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? 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 .Hour .Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		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 5/3/1959 to 5/7:59 and last saw ^{her} _{him} alive on 5/7/59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE  (Degree or title) 2		22b. ADDRESS Holden, Mo.	22c. DATE SIGNED 5/9/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5/9/59	23c. NAME OF CEMETERY OR CREMATORY Greenwood, Mo.	23d. LOCATION (City, town, or county) (State) Greenwood Mo.
24. FUNERAL DIRECTOR ADDRESS Langsford Funeral Home Lee's Summit, Mo.		25. DATE RECD. BY LOCAL REG. 5/16/59	26. REGISTRAR'S SIGNATURE Mrs. G. V. Redford

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 20 1959

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 *W.B. Langford*

Licensed Embalmer No. 3833 P. O. Address Lee's Summit, 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.