

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-023776

FILED JUL 13 1959

Registration District No. 224 Primary Registration District No. 3072 Registrar's No. 112

STATE FILE NUMBER

| | | | | | | | | |
|---|--|---|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Saline | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall | | Length of stay in 1b | | c. CITY OR TOWN Marshall | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Johnson Nursing Home | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 431 East Arrow | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Lilian Middle Bowen Last Bowen | | | | 4. DATE OF DEATH Month July Day 3rd Year 1959 | | | | |
| 5. SEX Female | 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 Aug. 9, 1873 | 9. AGE (last birthday) 85 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerk | | | 10b. KIND OF BUSINESS OR INDUSTRY Bank | | 11. BIRTHPLACE (City and state or country) Palmyra, Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Littleton P. Bowen | | | 13b. MOTHER'S MAIDEN NAME Ellen M. Powell | | | 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 | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. J. C. Drake Address Marshall, 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) Myocardial Gulmonary edema Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 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 _____ a.m. _____ p.m. Month, Day, Year _____ | | | 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 1949 to 7-8-59 and last saw her him alive on 7-3-59 Death occurred at 5-15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) John Lawrence M.D. | | | | 22b. ADDRESS Marshall, Mo | | 22c. DATE SIGNED 7-5-59 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 7-5-1959 | 23c. NAME OF CEMETERY OR CREMATORY Ridge Park cemetery | | 23d. LOCATION (City, town, or county) (State) Marshall, Missouri | | | |
| 24. FUNERAL DIRECTOR Campbell-Lewis, Marshall, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 7-5-59 | | 26. REGISTRAR'S SIGNATURE Carl A. Reed | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed.

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

RW Campbell

Licensed Embalmer No. *346*

P. O. Address *Marsha*

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