URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 12 1960

-60-025677

STATE FILE NUMBER

NDED

Registration District No. 009 Primary Registration District No. 5019 Registrar's No. 55

1. PLACE OF DEATH
a. COUNTY ANDREW
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ROCHESTER TOWNSHIP
Length of stay in 1b: 40 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION SHADY LAWN
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY ANDREW
c. CITY OR TOWN RFD # 4, Savannah
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 5 miles east Savannah
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: LENA Middle: Last: BOWERS
4. DATE OF DEATH Month, Day, Year: August 8, 1960
5. SEX: female
6. COLOR OR RACE: white
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 7-15-75
9. AGE (last birthday): 85
IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (City and state or country): Switzerland
12. CITIZEN OF WHAT COUNTRY: U S A
13a. FATHER'S NAME: Jacob Blaser
13b. MOTHER'S MAIDEN NAME: unk.
14. NAME OF HUSBAND OR WIFE: Charles Bowers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: - - -
17. INFORMANT: Mrs. Louise Masoner, Address: Amazonia, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral-vascular accident with right sided paralysis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
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)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE 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 2-13-56, to 8-8-60 and last saw her alive on 8-6-60
Death occurred at 7:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Warren C. Baker (Degree or title) M.D.
22b. ADDRESS: Savannah, Missouri
22c. DATE SIGNED: 8-8-60

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 8-9-60
23c. NAME OF CEMETERY OR CREMATORY: St. Johns Cemetery
23d. LOCATION (City, town, or county) (State): Amazonia, Missouri

24. FUNERAL DIRECTOR: BREIT & HAWKINS ADDRESS: SAVANNAH
25. DATE RECD. BY LOCAL REG.: 8-9-60
26. REGISTRAR'S SIGNATURE: Lillian Sparks

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4536

P. O. Address _____

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