

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-042615

FILED VS NOV 29 1960

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. \_\_\_\_\_ Registrar's No. 169

1. PLACE OF DEATH a. COUNTY <u>Laclede.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Dove, Missouri.</u>	Length of stay in 1b <u>3 wks.</u>	c. CITY OR TOWN <u>Richland, Missouri</u>	Institution Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cedar Grove N.Home.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>None.</u>
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Jamima</u> Last <u>Bowling.</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>17,</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/30/76</u>
9. AGE (last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u>	IF UNDER 24 HR Hours <u></u> Min. <u></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>Tuscumbia, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>William G. Reed.</u>	
13b. MOTHER'S MAIDEN NAME <u>Rachel Wyrick.</u>		14. NAME OF HUSBAND OR WIFE <u>John Bowling.</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. <u>None.</u>	17. INFORMANT Address <u>Mrs. Mack Henson. Richland, Mo.</u>
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>Empyema of Gall Bladder</u> and DUE TO (b) <u>Massive Gastro intestinal hemorrhage Cause and effect</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> <u>36 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Massive Gastro intestinal Hemorrhage.</u>			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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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 <u>16 Nov 60</u> to <u>17 Nov 60</u> and last saw her <sup>her</sup> <sub>alive</sub> on <u>16 Nov 60</u> Death occurred at <u>9:30</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE <u>Paula Jenkins</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>Lebanon, Missouri</u>	
22c. DATE SIGNED <u>19 Nov. 1960</u>		23. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23d. LOCATION (City, town, or county) (State) <u>Richland, Missouri</u>	
23b. DATE <u>11/30/60</u>		24. BURIAL DIRECTOR <u>Hedges Funeral Home Richland, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>11-20-1960</u>		26. REGISTRAR'S SIGNATURE <u>Wella L. Day</u>	

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 by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Clarence E. Mast

Licensed Embalmer No. 4896

P. O. Address Waynesville, M

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