

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 5 1961

60-045047  
STATE FILE NUMBER

Registration District No. 6 Primary Registration District No. 5031 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Audrain</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Loutre (Qui Vive Parish) Shortville</u> Length of stay in 1b _____			c. CITY OR TOWN <u>Laddonia</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>5 mi. north, 3 mi. west of Laddonia</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			d. STREET ADDRESS <u>5 mi North, 3 mi. west of Laddonia</u> (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>Joshua</u> Last <u>Bowen</u>			4. DATE OF DEATH Month <u>December</u> Day <u>28</u> , Year <u>1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-08</u>	9. AGE (last birthday) <u>52</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operatore</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Laddonia, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>B. Hester Bowen</u>		13b. MOTHER'S MAIDEN NAME <u>Neva Lee Barnes</u>		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) <u>no</u>		16. SOCIAL SECURITY NO. <u>493-28-3027</u>	17. INFORMANT <u>Mrs. Gray,</u> Address <u>Laddonia, 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>CIRCULATORY FAILURE (HEART BLOCK)</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> DUE TO (b) <u>CORONARY THROMBOSIS WITH MYOCARDIAL INFARCTION</u> <u>3 days</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u> <u>10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>HYPERTROPHIC BATHRITIS</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 _____ 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 <u>June 1952</u> to <u>Dec. 1960</u> and last saw him alive on <u>Dec. 28 1960</u> Death occurred at <u>7:15</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>William W Jones D.O.</u>			22b. ADDRESS <u>Laddonia, Mo</u>		22c. DATE SIGNED <u>12-29-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-30-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Farber Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Farber, Missouri</u>	
24. FUNERAL DIRECTOR <u>William Hester, Audrain, Mo</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>JAN 3. 1961</u>		26. REGISTRAR'S SIGNATURE <u>Walter Tugues</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 25 1961

FEB 17 1961

*Follow*

**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 *Miles Bhatia*

Licensed Embalmer No. *4167*

P. O. Address *Vandalia*

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