

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

61-005955  
STATE FILE NUMBER

FILED VS FEB 16 1961

Registration District No. 226 Primary Registration District No. 5802 Registrar's No. 6

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH COUNTY <u>MONROE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MONROE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>DUNCANS BRIDGE</u>		c. CITY OR TOWN <u>DUNCANS BRIDGE MO</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME</u>		d. STREET ADDRESS (If outside, give location) <u>RED<sup>02</sup> CLARENCE MO</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ORPH R. BOWLWARE</u>		4. DATE OF DEATH Month Day Year <u>JAN 30 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 10, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>MONROE COUNTY MO</u>
13a. FATHER'S NAME <u>JOSEPH BOWLWARE</u>		13b. MOTHER'S MAIDEN NAME <u>ANN SMIDOW</u>	14. NAME OF HUSBAND OR WIFE <u>BEULAH BOWLWARE</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 JOHN HENDREN MADISON 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>Chronic Bronchiectasis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pulmonary Congestion</u>			<u>2 Weeks</u>
DUE TO (c) <u>Acute Myocardial Failure</u>			<u>2 Weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>526X</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> <u>C</u>			
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 WORK <input type="checkbox"/> 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>Jan 16, 1961</u> to <u>Jan 30, 1961</u> and last saw him alive on <u>Jan 30, 1961</u> Death occurred at <u>9:10 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>B. L. Edgington, D.O.</u>		22b. ADDRESS <u>Clarence, Mo</u>	
		22c. DATE SIGNED <u>2-4-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>2-1-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONROE COUNTY MO</u>	
24. FUNERAL DIRECTOR <u>GREENING</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 6 - 1961</u>	
ADDRESS <u>CLARENCE MO</u>		26. REGISTRAR'S SIGNATURE <u>Clive Miller</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Charles V. Keening* .....

Licensed Embalmer No. *4625* .....

P. O. Address *Clarence Ma* .....

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.