SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-024739

STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. Town Registrar's No. 669

FILED JUL 24 1961

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mercy Hospital
Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Greene
c. CITY OR TOWN Springfield
Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 730 W. Scott
Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Clinton Middle H. Last Bowman
4. DATE OF DEATH Month July Day 11 Year 1961
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH Aug. 23 1883
9. AGE (last birthday) 77
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) Retired Merchant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Hagerstown Ind.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Ithamer Bowman
13b. MOTHER'S MAIDEN NAME Susannah Hardman
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
17. INFORMANT Mrs. Pearl Glenn Address 730 W. Scott Spfd 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 — INTERVAL BETWEEN ONSET AND DEATH 36 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) arteriosclerotic Vascular dis. — Unknown
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pemphigus
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 Springfield COUNTY Greene STATE Mo.

21. I attended the deceased from Aug 23 '55, to July 11 '61 and last saw ~~him~~ alive on July 11 '61
Death occurred at 1:45 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [illegible] M.D.
22b. ADDRESS 609 Cherry St.
22c. DATE SIGNED 14 July '61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 7-13-61
23c. NAME OF CEMETERY ~~OR CREMATORY~~ Seymour Masonic
23d. LOCATION (City, town, or county) Webster Co. (State) Missouri

24. FUNERAL DIRECTOR Robert Bergman ADDRESS Seymour, Mo.
25. DATE RECD. BY LOCAL REG. 7-17-61
26. REGISTRAR'S SIGNATURE Effie E. Melton

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — BY AFFIDAVIT OF

JUL 25 1961

NOV 9 1961

NOV 14 1961

NOV 2 1961

MAY 10 1962

NOV 2 1962

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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Mansfield M

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.