

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

31659

**1. PLACE OF DEATH**

County Randolph  
Township Moberly  
City Moberly (No. 523 Barrow)

Registration District No. 735  
Primary Registration District No. 3034

File No. \_\_\_\_\_  
Registered No. 188  
St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 523 Barrow St. \_\_\_\_\_ Ward. \_\_\_\_\_

(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>March 29<sup>th</sup> 1928</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>1</u>	<u>6</u>	<u>4</u>	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>None</u>				
(b) General nature of industry, business, or establishment in which employed (or employer) _____				
(c) Name of employer _____				

9. BIRTHPLACE (CITY OR TOWN) Mo  
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Grover Bowers</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Mo</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Maggie Pigg</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Mo</u> (STATE OR COUNTRY)

14. INFORMANT Grover Bowers  
(Address) Moberly Mo.

15. FILED 10/9, 1929 Dr. Thos. J. Fleming  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 26<sup>th</sup> 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 25, 1929 to Sept 26, 1929 that I last saw h. ex. alive on Sept 26, 1929 and that death occurred, on the date stated above, at 6:45 PM m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Broncho Pneumonia  
1929 (duration) yrs. mos. ds. 2  
12 Anesthetic, Button in trachea  
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRAILED Mo  
IF NOT AT PLACE OF DEATH. yes

19. DID AN OPERATION PRECEDE DEATH. yes DATE OF Sept 26-29

20. WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS Clinical, X Ray.  
(Signed) R. A. Mitchell, M. D.  
9-28, 1929 (Address) Moberly Mo.

\*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Moberly Mo. DATE OF BURIAL 9-28<sup>th</sup> 1929

20. UNDERTAKER Mahaw Anderson ADDRESS Moberly Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

