

SEP 25 1930

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

Do not use this space.

27175

1. PLACE OF DEATH

County Ray
Township Ray
City Ray

Registration District No. 460
Primary Registration District No. 5224-a

File No. _____
Registered No. 75
St. _____ Ward) _____

2. FULL NAME

Friedrich C. Bowering
(a) Residence. No. _____ 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IS MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. F. C. Bowering

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 13, 1867

7. AGE YEARS MONTHS DAYS If LESS than Y day, _____ hrs. or _____ min.
63 7 9

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Berger mo
(STATE OR COUNTRY)

10. NAME OF FATHER Carl Bowering

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Flora Weller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

14. INFORMANT Mrs. F. C. Bowering
(Address) Raymsville Mo

15. FILED 8/29/30 Bessie Porter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 22 1930

17. I HEREBY CERTIFY, That I attended deceased on 2-29-1928, 19 and 8-22, 1930 that I last saw h. alive on 8-22, 1930, and that death occurred, on the date stated above, at 4:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis pulmonary chronic
23H
(duration) 9 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) SI
(duration) _____ yrs. mos. ds.)

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

19. WHAT TEST CONFIRMED DIAGNOSIS Physical findings
(Signed) W. H. Koppelman, M. D.

*, 1930. (Address) Raymsville Mo
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Evangelical Cem. DATE OF BURIAL Aug 24 1930

20. UNDERTAKER Hafer & Memersdorf ADDRESS Raymsville Mo

K. 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.

