

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

File 12647742

Do not use this space.

1. PLACE OF DEATH *Phelps* ² Registration District No. *677*
 (a) County *Phelps* ⁰ (b) Township *Phelps* Primary Registration District No. *4403*
 (c) City *Ralla* (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *James J Bowen*
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *V*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Hanna Poe Bowen*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 24, 1854*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
86 0 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *at Home*

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Illinois*

13. NAME *Joseph Bowen*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*

15. MAIDEN NAME *Don't know*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*

17. INFORMANT (ADDRESS) *John Bowen Ralla Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Ralla* DATE *1/31* 19*40*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Mrs Harry Mc Caw Ralla Mo*

20. FILED *Feb 1* 19*40* *Jos. F. Ayers* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *1/29* 19*40*

22. I HEREBY CERTIFY, That I attended deceased from *April 1* 19*39* to *Jan 10* 19*40*
 I last saw him alive on *Jan 10* 19*40* Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

Cordic Decomposition
 Date of onset _____

Other contributory causes of importance:

arteriosclerosis
Senility

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19*40*

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) *Paul H. Tucker* M. D.610 (Address) *St. James, Mo*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{was not} ~~was~~ embalmed by ~~me~~, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number 340323

Date Filed 31240

Signed

W Mrs Harry McCaw

Licensed Embalmer No. 1814

P. O. Address Polla Mo

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 7742

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. 11(17)

1. PLACE OF DEATH

(a) County Phelps
(b) City or town Rolla
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME James J. Bowen

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Do not know - not living together 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased HANAH COE BOWEN
(Month) (Day) (Year)

8. AGE: Years 86 Months 0 Days 5 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) April 18, 1940 (b) Joe F. Myers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Phelps
(c) City or town Rolla
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. MEDICAL CERTIFICATION

20. DATE OF DEATH Month 1 day 29
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) _____
Means of injury _____

23. Signature E. A. Strickler
Address St James

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

