

No. 2
1-10-39
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K21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10305

FILED APR 12 1940

Registration District No. 86

Primary Registration District No. 5127

Registrar's No. 281

1. PLACE OF DEATH:

(a) County Buchanan MO
(b) City or town Washington Twp (RURAL)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
40th FARRON
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 28 YEARS.
years, months or days

3. (a) PRINT FULL NAME Jelitha Mae Bowers 620

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

4. Sex FEMALE 5. Color or race white 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Charles Bowers 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased July 20th 1888
(Month) (Day) (Year)

8. AGE: Years 51 Months 7 Days 18
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name HENRY THARP

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

14. Maiden name ELIZABETH (UNK) 0

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

16. (a) Informant Charles Bowers

(b) Address 40th FARRON St. Joseph Mo.

17. (a) BURIAL (b) Date thereof MAR 11 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address St. Joseph Mo.

19. (a) Mar 11 1940 (b) A. J. Nestleburg
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan
(c) City or town St Joseph (RURAL)
(If outside city or town limits, write "RURAL")
(d) Street No 40th FARRON
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 8th
year 1940 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from VIEWED
_____ 19 _____ to _____ 19 _____

that I last saw him examined on MAR 8th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis Duration _____

Due to Intestinal Obstruction ✓

Due to _____

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

Major findings: Of operations None

Of autopsy None

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? _____

85 While at work? _____ (Specify type of place) (e) Means of Injury _____

23. Signature Dr. Raymond L. Smith (M. D. or other) DO

Address 223 Kentucky Bldg Date signed 3/18/40

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

122/2

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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No. 4082

P. O. Address.....

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.

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STANDARD CERTIFICATE OF DEATH

State File No. 10305

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 86

Primary Registration District No. 3127

Registrar's No. 281

1. PLACE OF DEATH:

(a) County... Buchanan
(b) City or town... Washington Ins
(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... years, months or days)

3. (a) PRINT FULL NAME... Selitha Mae Bowen

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

4. Sex... 7 5. Color or race... W 6. (a) Single, widowed, married, divorced... m

6. (b) Name of husband or wife... 6. (c) Age of husband, or wife, if alive... year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 31 Months 7 Days 18 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) (Burial, cremation, or removal) (b) Date thereof... (Month) (Day) (Year)

(c) Place: burial or cremation...

18. (a) Signature of funeral director... (b) Address...

19. (a) 5-29-40 (Date received local registrar) (b) H. J. Nestleboer (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State... (b) County...

(c) City or town... (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month... Mar day... 8 year... 1940 hour... minute... M.

21. I hereby certify that I attended the deceased from... 19... to... 19...

that I last saw him alive on... and that death occurred on the date and hour stated above.

Immediate cause of death... Peritonitis

Intestinal obstruction

Due to surgery performed previously when gallbladder was left

Due to an wound scar tissue left

formed partial obstruction - this is patient's husband's statement.

Other conditions... (include pregnancy within 3 months of death)

Major findings: Of operations... 1220

Of autopsy...

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) (Specify type of place) (Month) (Year) (Day) (Hour) (Minute) (Second) (Other)

23. Signature... Raymond T. South... Address... St. Joseph

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

SUPPLEMENTAL

S-12365 1940