

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

19089

State File No. _____

Registration District No. _____ Primary Registration District No. 5-806 Registrar's No. _____

1. PLACE OF DEATH:

(a) County NEW MADRID.
(b) City or town ITURAL (PORTAGE) MISSOURI
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution No
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No
In this community FEBRUARY, 1940 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 5 Miles E. of Newton
(If rural, give location)
(e) If foreign born, how long in U. S. A.? No years

8. (a) PRINT FULL NAME BLUM BOWEN 500

3. (b) If veteran, name war World War 3. (c) Social Security No. None

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

6. (b) Name of husband or wife ROY BOWEN 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased August 18 97
(Month) (Day) (Year)

8. AGE: Years About 43 Months . Days . If less than one day hr. min.

9. Birthplace New Madrid Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farming (Ray Works)

11. Industry or business _____

MOTHER FATHER { 12. Name unk.

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

14. Maiden name unk.

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

16. (a) Informant Ray Bowen
(b) Address Portageville, Mo. R. 1

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Portageville, Mo

18. (a) Signature of funeral director L. H. ...
(b) Address New Madrid Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12
year 1940 hour 6:00 minute 0 M.

21. I hereby certify that I attended the deceased from June 12, 1940 to June 12, 1940
that I last saw him alive on June 12, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Indigestion

Due to _____

Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

Duration 4 hours

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? 535

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

23. Signature Doyle M. Raven (M. D. or other) _____

Address Portageville, Mo Date signed June 12, 1940

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

118c

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.....

Les Hedgworth..... Registered Apprentice No.....
working under my personal supervision.

Signed *Les Hedgworth*.....

Licensed Embalmer No: *3803*

P. O. Address *New Madrid, 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

State File No. **19089**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **607**

Primary Registration District No. **5806**

Registrar's No.

MOORE

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

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Postage T.P.
(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

Blum Bowen

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race col

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 abt 43 Months _____ Days _____ If less than one day hr. 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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 June day 12
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 _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death acute indigestion

Due to Heart disease

Due to 1150

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

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) (e) Means of injury _____

23. Signature Clayton McRaven (Registrar's signature)
Address Marston Date signed _____

SUPPLEMENTARY

Registration District No. 607

Primary Registration District No. 5806

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Paragage
(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 _____
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

Blum Bower

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race e 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 abt 43 Months Days 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) (b) Mary W. Crote (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 June day 12 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 _____, 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) (e) Means of injury _____

23. Signature Clarence Bower (M. D. or other)

Address Marston Date signed _____

SUPPLEMENTAL

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