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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35341

Registration District No. 3 FILED NOV 12 1940 Primary Registration District No. 2001 Registrar's No. 859

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 411 E. Atlantic (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days) In this community HARTSELL

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Greene
(c) City or town Springfield (If outside city or town limits, write "RURAL")
(d) Street No. 411 E. Atlantic (If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME HARRIETT L. BOWERS.
3. (b) If veteran, name war No.
3. (c) Social Security No. No
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive Dec years
7. Birth date of deceased Nov. 27 (Month) 1854 (Day) (Year)

8. AGE: Years 85 Months 10 Days 20 If less than one day ..... hr. ..... min.

9. Birthplace Nashville (City, town, or county) Ill. (State or foreign country)
10. Usual occupation House Wife
11. Industry or business In home
MOTHER FATHER
12. Name Dickson Lyons
13. Birthplace Unknown (City, town, or county) Ky. (State or foreign country)
MOTHER
14. Maiden name Sarah Jane (Unknown)
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Nellie E. Gorman
(b) Address Springfield Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Greendown
18. (a) Signature of funeral director J. W. Klingner & Co
(b) Address Springfield, Mo
19. (a) 10-19-40 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17 year 1940 hour 7 minute 20 A. M.
21. I hereby certify that I attended the deceased from 10/11/40, 19..., to 10/15/40 19...; that I last saw her alive on 10/15, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myo Carditis with Cardiac failure or decompensation — Duration 1/40
Due to
Due to
Other conditions Senility (Include pregnancy within 3 months of death) A & C
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? (Specify type of place)
While at work? (e) Means of injury
Signature C. E. Feller (M. D. ~~coroner~~) Address Springfield Mo. Date signed 10/12/40

(Licensed Embalmer's Statement on Reverse Side)

21

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 Ogle Lane Jr., Registered Apprentice No. 232 working under my personal supervision.

Signed Warren D. Noblett

Licensed Embalmer No. 4095

P. O. Address Springfield Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.