

Registration District No. **392**

Primary Registration District No. **4231**

Registrar's No. **11**

1. PLACE OF DEATH:

(a) County **Iron**
(b) City or town **Pilot Knob**
(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 **eight months** years, months or days _____

3. (a) PRINT FULL NAME **Oscar Earl Bowman**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **518-07-8766**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Married status unknown**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Dec. 23, 1895** (Month) (Day) (Year)

8. AGE: Years **44** Months **10** Days **28** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Laborer** 9

11. Industry or business _____

12. Name **Unknown** 9

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

14. Maiden name **Unknown** 11

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

16. (a) Informant **Person on this person**
(b) Address _____

17. (a) **Buried** (b) Date thereof **Nov. 23, 40** (Month) (Day) (Year)
(c) Place: burial or cremation **Pilot Knob, Mo**

18. (a) Signature of funeral director **Norman White & Sons**
(b) Address **A. J. White Ironton Mo.**

19. (a) **Nov 22 1940** (b) **L. J. Effinger** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Iron**
(c) City or town **Pilot Knob**
(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 **11** day **21st** year **1940** hour **11** minute **A. 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 **suicide, as a result of taking poison by his own hands.**

Due to _____
Other conditions **none** (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

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? **3511**

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature **Willard D. Beulow** (Registrar's signature)
Address **Ironton, Mo** Date signed **Nov 24, 1940**

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

FILED DEC 21 1940

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

AUG 5 1941

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 Arnold J. White

Licensed Embalmer No. 3012

P. O. Address Evansville, Ind.

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. 38849

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 392

Primary Registration District No. 4231

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Knob
(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 Dear Earl Bowman

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 inc

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

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

8. AGE: Years 44 Months 10 Days 28 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 (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 11 day 21
year _____ 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 Suicide as result of taking poison by his own hands

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 1/62

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) Suicide
(b) Date of occurrence 11-21-40
(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? Mar Home Plat Inst. Mo.
While at work? (Specify type of place) (e) Means of injury Poison

23. Signature W. D. Bauer (M. D. or other) _____
Address Fronton, Mo. Date signed 1-29-41

SUPPLEMENTAL

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

MOORE

S-38849, 1940