

No. 2  
1-13-40  
-17-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

24374  
State File No. \_\_\_\_\_  
Registrar's No. 39

FILLED AUG 14 1941

Registration District No. \_\_\_\_\_ Primary Registration District No. 205

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

1. PLACE OF DEATH:  
(a) County Andrew  
(b) City or town Nodaway Township  
(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 65 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED: 002  
(a) State Missouri (b) County Andrew  
(c) City or town Nodaway Township  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULLNAME BENJAMIN UNSEL BOWMAN

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 2 divorced w

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

7. Birth date of deceased Feb 16 1860  
(Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace UN KNOWN INDIANA  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business \_\_\_\_\_

12. Name JACOB AARON BOWMAN

13. Birthplace UN KNOWN KANKAKEE  
(City, town, or county) (State or foreign country)

14. Maiden name MARY HUBER

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

16. (a) Informant Mrs Edith Bowman

(b) Address Savannah Mo

17. (a) \_\_\_\_\_ (b) Date thereof 8-1-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah

18. (a) Signature of funeral director E. B. Breit

(b) Address Savannah Mo

19. (a) Aug 1 - 41 (b) Mrs Jennie Rach  
(Date received local registrar) (Registrar's signature)

107 (Licensed Embelmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30  
year 1941 hour 12 minute 45 P.M.

21. I hereby certify that I attended the deceased from Dec 15 1940  
to July 30 1941  
that I last saw him alive on July 18 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to High Blood Pressure

Due to \_\_\_\_\_

Other conditions First Stroke 1932  
(Include pregnancy within 3 months of death)  
Invalid since

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? \_\_\_\_\_

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

23. Signature J. C. Hoshor (M. D. or other) D

Address Savannah Mo Date signed 8/1-41

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

**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.....

*E. C. Breit*

Licensed Embalmer No.....

*2650*

P. O. Address.....

*Swansea, Md*

**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, fact should be so stated above.**