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5-17-39  
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 11 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14127

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
638 No. 14th St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 32 years.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 638 No. 14th St.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 7

If yes, name country 0

3. (a) PRINT FULL NAME Lucretia Elizabeth Bowers

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31  
year 1944 hour 6:00 minute \_\_\_\_\_ P. M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced. Married

6. (b) Name of husband or wife Alcid Bowers.

6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased December 9 1858  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 24, 1943 to Mar 31, 1944, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

<u>85</u>	<u>6</u>	<u>19</u>	hr. _____ min. _____
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Immediate cause of death Cerebral Occlusion Duration 1 da.

Due to arterio sclerosis ischemia

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Columbus, Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER { 12. Name Nicholas Harrington

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

14. Maiden name Delilla Wynkoop

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Alcid Bowers-Sr.

(b) Address 638 No. 14th St.

17. (a) Burial (b) Date thereof April 4, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Mora Cemetery

18. (a) Signature of funeral director Hermon S. Dwyer

(b) Address 1802 Union St.

19. (a) 4-4-44 (b) Rose Hargoy  
(Date received local registrar) (Registrar's signature)

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 0

23. Signature H. L. Kearby M.D. (M. D. or other)

Address St. Joseph, Mo. Date signed 4-21-44

1233

(Licensed Embalmer's Statement on Reverse Side)

OCT 20 1958

OCT 23 1958

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**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.....

*Robert H. Reed*

Licensed Embalmer No. ....

*3745*

P. O. Address.....

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