

No. 2  
-12-45  
5-17-39  
PI X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED NOV 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36982**  
Registrar's No. **165**

Registration District No. 10 Primary Registration District No. 3035

1. PLACE OF DEATH:

(a) County Audrain  
(b) City or town Centralia Rural Soaring  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
R 719 # 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Audrain  
(c) City or town Centralia Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. R 719 # 2  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Samuel Jackson Bowne

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 ✓ 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Oct. 22 1878  
(Month) (Day) (Year)

8. AGE: Years: 69 Months: 0 Days: 19 If less than one day hr. min.

9. Birthplace Audrain county Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

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

12. Name Adam Bowne

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

14. Maiden name Elizabeth Teeters

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

16. (a) Informant Sister

(b) Address Centralia Mo

17. (a) Burial (b) Date thereof NOV. 15 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Appleman's Chapel

18. (a) Signature of funeral director Profferty

(b) Address Centralia Mo

19. (a) 11/15/47 (b) Blanche Neely  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 11th  
year 1947 hour 1 minute 50 A. M.

21. I hereby certify that I attended the deceased from 2-6-43 1943 to 11-11-47 1947  
and that I last saw him alive on 11-7-47 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Degeneration

Due to Hypertension

Due to Chronic Interstitial Nephritis

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

Major findings: Of operations 13/10

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 Dr. Baker (M. D. or other) \_\_\_\_\_

Address Centralia Mo Date signed 11-15-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Officer No. 10  
District File Number 11-47-1616  
Date Filed NOV 25 1947

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 *George Jernig*  
Licensed Embalmer No.....  
P. O. Address *Centralia 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.