

FILED JAN 8 1948

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

Registration District No. 238

Primary Registration District No. 5823

Registrar's No. 255

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Sikeston R#3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 2 wks  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott 100  
(c) City or town Marley 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No) 1  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ROBERT BRUCE BOWEN

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

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

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

7. Birth date of deceased Oct 17 1875  
(Month) (Day) (Year)

8. AGE: Years 72 Months - Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation ret. Farmer

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

12. Name Elva Bowen

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

14. Maiden name Charity

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

16. (a) Informant Noble Bowen

(b) Address Sikeston Mo

17. (a) Burial (b) Date thereof 10-21-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marley Mo

18. (a) Signature of funeral director Welch Funeral Home  
(b) Address Sikeston Mo

19. (a) 12-16-47 (b) Helen Lind Jones  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20  
year 1947 hour 2 minute 30 A. .M.

21. I hereby certify that I attended the deceased from 10/1/47  
10/19/47, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on 10/19/47  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

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

Major findings: 93%  
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? 2

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

23. Signature M. Daniel (M. D. or other) DD  
Address Sikeston Mo Date signed 10/29/47

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

RECEIVED

District Health Office No. 2,

District File Number 148-32

Date Filed 1-5-48

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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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Shelton Ms

**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.**