

FILED OCT 25 1948

Registration District No. **228**

Primary Registration District No. **2000**

Registrar's No. **907**

1. PLACE OF DEATH:
Greene
(a) County **Greene**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
411 Hovey
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **60 Years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Thomas K. Bowman**
3. (b) If veteran, name war. **None**
3. (c) Social Security No. **None**

4. Sex **Male** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Martha Bowman**
6. (c) Age of husband or wife if alive **? years**
7. Birth date of deceased. **November 6 1859**
(Month) (Day) (Year)

8. AGE: Years **88** Months **11** Days **11** If less than one day hr. min.

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

10. Usual occupation **Contractor**

11. Industry or business **Retired Contractor**

MOTHER FATHER
12. Name **Samuel Bowman**
13. Birthplace **Apollo Pennsylvania**
(City, town, or county) (State or foreign country)
14. Maiden name **Agnes Rengle**
15. Birthplace **Pennsylvania**
(City, town, or county) (State or foreign country)

16. (a) Informant **Martha Bowman (Wife)**
(b) Address **Springfield, Missouri**

17. (a) Burial **(b) Date thereof** **10-21-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place of burial or cremation **Greenlawn Cemetery**

18. (a) Signature of funeral director **J.W. Klingner & Co.**
(b) Address **Springfield, Missouri**

19. (a) 10-22-48 (b) M. J. Haulley MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
Missouri Greene
(a) State (b) County
(c) City or town **Springfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **411 Hovey**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** day **17**
year **1948** hour **1** minute **45** P.M.
21. I hereby certify that I attended the deceased from **10 Oct. 48**
1948, to **Oct 17 1948**
that I last saw him alive on **10 Oct.** 1948
and that death occurred on the date and hour stated above.

Immediate cause of death
Cardiac failure
Due to **Arteriosclerosis**
Due to **Senility**
Other conditions (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?

23. Signature **Samuel E. Small, M.D.**
Address **1630 N. Jefferson** **Date signed** **21 Oct 48**
(Specify type of place) (e) Means of injury (M.D. or other)

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

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

1918

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 *Max Rhodes*

Licensed Embalmer No. *4071*

P. O. Address *Springfield*

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.