

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 30 1949

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

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>5764</u>		Registrar's No. <u>17</u>			
1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>					
b. CITY OR TOWN <u>Rural</u>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>Rural</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Berna</u>			b. (Middle)			c. (Last) <u>Bowers</u>			
4. DATE OF DEATH (Month) (Day) (Year) <u>3 12-1949</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>Nov 20-1887</u>			
9. AGE (In years last birthday) <u>62</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			
13a. FATHER'S NAME <u>James D. Murdick</u>			13b. MOTHER'S MAIDEN NAME <u>Rachel H. Mee</u>			14. NAME OF HUSBAND OR WIFE <u>Sam Bowers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>C. Marie Feaster Philadelphia Mo</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Found dead in bed</u> ANTECEDENT CAUSES DUE TO (b) <u>Cause unknown</u> DUE TO (c) <u>Poor health some while</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <u>no</u>		19b. MAJOR FINDINGS OF OPERATION <u>7955</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>W. Crawford Smith Coroner</u>				23b. ADDRESS <u>Harrison Mo</u>		23c. DATE SIGNED <u>3-12-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-14-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Andrew Chapel Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Marion Missouri</u>			
DATE REC'D BY LOCAL REG. <u>3-12-49</u>		REGISTRAR'S SIGNATURE <u>By Viola Green, Reg.</u>		FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ben M. Allen, Phila Mo</u>					

(Licensed Embalmer's Statement on Reverse Side)

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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed B M Allen

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2437

P. O. Address Philadelphia, Pa.

**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.