

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **29296**

No. 300
10.48

FILED SEP 19 1949

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 959

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

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY <u>Buchanan</u>		a. STATE <u>Missouri</u>	b. COUNTY <u>Buchanan</u>
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph, Mo.</u>	c. LENGTH OF STAY (in this place) <u>6 Days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph, Missouri</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Mo. Methodist Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>V 2417 South 19th Street</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Alcid</u>	b. (Middle)	c. (Last) <u>Bowers</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 3 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 10, 1860</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Attorney</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Law office</u>	11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF DECEASED'S WIFE <u>Florence</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Alcid Bowers 2417 So. 19th St</u>	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Embolism</u>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Mural thrombus left auricle with arrhythmia</u>	<u>?</u>
	DUE TO (c) <u>Arteriosclerotic heart disease plus atheroma</u>	<u>9</u>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>332X</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>7-3</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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2. I hereby certify that I attended the deceased from 8-26, 1947, to 9-3, 1947, that I last saw the deceased alive on 7-3, 1947, and that death occurred at 4:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Lucile N. Id. M.D.</u>	23b. ADDRESS <u>902 Edmund St. City</u>	23c. DATE SIGNED <u>9-6-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9/6/1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Highland Kansas</u>
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DATE REC'D BY LOCAL REG. <u>Sept. 7, 1949</u>	REGISTRAR'S SIGNATURE <u>H. B. Jenkins</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Herman H. Sienkaden 1802 Edmund St</u>
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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 _____

working under my personal supervision.

Student
Student Embalmer

Signed

Student Embalmer No.
Robert H. Yaph

Licensed Embalmer No. *3308*

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.