

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

37878

State File No. _____

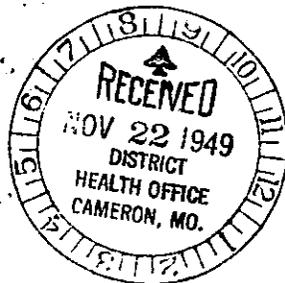
FILED NOV 29 1949

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 168

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Chillicothe</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Chillicothe</u>	
c. LENGTH OF STAY (in this place) <u>1 yr.</u>		d. STREET ADDRESS (If rural, give location) <u>615 Ann St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>615 Ann St.</u>		e. FULL NAME OF HOSPITAL OR INSTITUTION <u>615 Ann St.</u>	
3. NAME OF DECEASED a. (First) <u>Annie</u>		b. (Middle) <u>Maria</u>	
c. (Last) <u>Bowes</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 11, 1949</u>	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 14, 1962</u>
9. AGE (In years last birthday) <u>87</u>		10. MONTHS <u>7</u>	11. DAYS <u>9</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Macomb, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Samuel Kenyon</u>		13b. MOTHER'S MAIDEN NAME <u>Mary E. Atkinson</u>	
14. NAME OF HUSBAND OR WIFE <u>Gerome P. Bowes</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates attached) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Frank Wolfskill - Kansas City, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4222</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <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 <u>Jan 10, 1945</u> , to <u>Nov 11, 1949</u> , that I last saw the deceased alive on <u>Nov 5, 1949</u> , and that death occurred at <u>1.0</u> m., from the causes and on the date stated above.	
23a. SIGNATURE (Name or title) <u>D. Callen M.D.</u>		23b. ADDRESS <u>Chillicothe, Mo.</u>	
23c. DATE SIGNED <u>11/11/49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>11/13/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Wheeling</u>	
24d. LOCATION (City, town, or county) (State) <u>Wheeling, Mo.</u>		DATE REC'D BY LOCAL REG. <u>Nov-12-49</u>	
REGISTRAR'S SIGNATURE <u>Frances B. Neill</u>		FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Donald Jordan, Chillicothe, Mo.</u>	

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

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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.

Student
Student Embalmer

Signed

Ronald Gordon

Licensed Embalmer No. 4191

P. O. Address Phillips, 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.