

FILED JAN 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43953**

BIRTH MO. _____ REG. DIST. NO. **340** PRIMARY REG. DIST. NO. **4503** Registrar's No. **5**

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bernie		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bernie 1030	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 1030	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) Grace	b. (Middle) Myrtle	c. (Last) Bowman	4. DATE OF DEATH (Month) (Day) (Year) Dec. 27, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 4, 1897	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months 4 Days 23	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Stoddard County, Mo. ()	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Wm. H. Crutchfield	13b. MOTHER'S MAIDEN NAME Addie Nations	14. NAME OF HUSBAND OR WIFE Dewey I. Bowman
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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) NO	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Dewey I. Bowman ADDRESS Bernie, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Sudden
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Trauma on chest. Possible internal injuries.		
	ANTECEDENT CAUSES DUE TO (b) Chronic myocarditis which caused dizziness and loss of control of automobile which she was driving.		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 25	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Bernie Stoddard Mo.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec. 27, 1949 m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Automobile crash.
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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 **10:45 A.M.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wm. W. Rainey, Coroner	23b. ADDRESS Dexter, Missouri	23c. DATE SIGNED 12-27-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial ()	24b. DATE 12-30-49	24c. NAME OF CEMETERY OR CREMATORY Bernie	24d. LOCATION (City, town, or county) (State) Bernie, Missouri
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DATE REC'D BY LOCAL REG. 1-14-50	REGISTRAR'S SIGNATURE Valerie V. Jenkins	25. FUNERAL DIRECTOR'S SIGNATURE Strickland-Rainey ADDRESS Dexter, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 7 1950

RECEIVED JAN 16 1950
District Health Office N
District File Number 150-4
Date Filed

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 Embalmer Name _____

Signed _____

J. S. [Signature]

Licensed Embalmer No. 3479

P. O. Address Wester, Mo

Student Embalmer

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.