

FILED MAR 3 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4583

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 177

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give town or township) Springfield		c. LENGTH OF STAY (In this place) 8 hours		c. CITY (If outside corporate limits, write RURAL and give township) Rural, Franklin Twp. 0390 Fair Grove	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If rural, give location) Fair Grove R.F.D. # 2			

3. NAME OF DECEASED (Type or Print) a. (First) LINA		b. (Middle) L.		c. (Last) BOWLING		4. DATE OF DEATH (Month) (Day) (Year) Feb. 23, 1952	
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5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 10 Apr. 1909		9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Elsy, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME Urban Davis				13b. MOTHER'S MAIDEN NAME Stella Mounts				14. NAME OF HUSBAND OR WIFE John Bowling			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS John Bowling, Rt 2, Fair Grove, Mo.					
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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 9 hrs	
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I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intercranial hemorrhage</u>		DUE TO (b) <u>cause undetermined</u>		DUE TO (c)	
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II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
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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)		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) (Min.)		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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22. I hereby certify that I attended the deceased from 7:00 AM, 1952, to 7:30 AM, 1952, that I last saw the deceased alive on 23 Feb, 1952, and that death occurred at 10:00 AM, from the causes and on the date stated above.

23a. SIGNATURE <u>Robert W. Maher</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Medical Arts Bldg.</u>		23c. DATE SIGNED <u>25 Feb 52</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 25 Feb 1952		24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		24d. LOCATION (City, town, or county) (State) Springfield, Missouri.	
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DATE REC'D BY LOCAL REG. 2-25-52		REGISTRAR'S SIGNATURE <u>James H. Amos, M.D.</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Paul C. Phoenix</u>		ADDRESS <u>Springfield, Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Maher George (9:00 AM)

AUG 27 1957

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 Ralph H. Thiem

Licensed Embalmer No. 3681

P. O. Address Springfield, 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.