

FILED JUL 6 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17948**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **700**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Harrison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY OR TOWN Martinsville	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 1 day		e. STREET ADDRESS (If rural, give location) 0410	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Missouri Methodist Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Lura b. (Middle) _____ c. (Last) Bowen	4. DATE OF DEATH (Month) (Day) (Year) June 28, 1954
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Apr. 22, 1875	9. AGE (In years last birthday) 79	# UNDER 1 YEAR Months _____ Days _____	# UNDER 1 HR. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper	10b. KIND OF BUSINESS OR INDUSTRY housekeeping	11. BIRTHPLACE (City and State or Foreign Country) Worth County, Missouri		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME Alfred Owens	13b. MOTHER'S MAIDEN NAME Lucinda unknown	14. NAME OF HUSBAND OR WIFE Wm. Edward Bowen
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Mr. O. P. Bowen	ADDRESS 527 Chestnut, St. Joseph, 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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH less than 1 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis		undetermined
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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) 331X
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 **Feb. 4, 1954**, to **June 28, 1954**, that I last saw the deceased alive on **June 28, 1954**, and that death occurred at **10:30 Am.**, from the causes and on the date stated above.

23a. SIGNATURE <i>Clifton Smith M.D.</i>	23b. ADDRESS 218 N. 7th Street St. Joseph 54, Missouri	23c. DATE SIGNED June 29/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 6/29/54	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) Bethany, Missouri
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DATE REC'D BY LOCAL REG July 4, 1954	REGISTRAR'S SIGNATURE Kathleen M. Allison	485-0	25. FUNERAL DIRECTOR'S SIGNATURE Heaton-Bowman	ADDRESS St. Joseph Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

W. Christ

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.....
Signature of Student Embalmer

Signed..... *W.E. Edmouster*

Licensed Embalmer No. *4791*

P. O. Address *319 So. 10th St. Jax*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.