

FILED SEP 6 1955

STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 937

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 30 yrs		d. STREET ADDRESS (If rural, give location) 1115 N. 22nd Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital			

3. NAME OF DECEASED (Type or Print) Truman	a. (First)	b. (Middle)	c. (Last) Bowen	4. DATE OF DEATH (Month) (Day) (Year) August 24, 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH February 21, 1880	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Agent	10b. KIND OF BUSINESS OR INDUSTRY Insurance and Loans	11. BIRTHPLACE (City and State or Foreign Country) Easton, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Elijah Bowen	13b. MOTHER'S MAIDEN NAME Malinda Woodard	14. NAME OF HUSBAND OR WIFE Sarah Jane Bowen
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 491-10-3524	17. INFORMANT'S SIGNATURE OR NAME Mrs. Sarah Jane Bowen	ADDRESS St. Joseph, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastrointestinal bleeding	DUPLICATE (b) _____		6 wks
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUPLICATE (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 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) m.	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 Aug 22, 1955, to Aug 24, 1955, that I last saw the deceased alive on Aug 23, 1955, and that death occurred at 7:10A m., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) M.D.	23b. ADDRESS 902 Edmund St., City	23c. DATE SIGNED 8/25/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 26, 1955	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri.
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DATE REC'D BY LOCAL REG. Aug. 30, 1955	REGISTRAR'S SIGNATURE [Signature]	4853	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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

Albert R. Harrington

Licensed Embalmer No. 3258 Mo.

P. O. Address St. Joseph, Missouri.

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.