

pt. Health,
, & Welfare
S. Public
lth Service
1040
S. 300
v. 1-57

(THE DIVISION OF HEALTH OF MISSOURI)
STANDARD CERTIFICATE OF DEATH

47700
STATE FILE NUMBER

FILED JAN 23 1958

Registration District No. 347 Primary Registration District No. 4507 Registrar's No. 14

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|---|--|---|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Stone</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If in institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stone</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Crane</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Crane</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>E</u> Last <u>Bowling</u> | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>30</u> Year <u>1957</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept 25 - 1888</u> | | 9. AGE (In years last birthday) <u>69</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Lawrence Co.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13a. FATHER'S NAME <u>Lee Jackson</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Mrs. Bowling</u> | | 14. NAME OF HUSBAND OR WIFE <u>Frank Bowling</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Frank Bowling</u> Address <u>Crane Mo</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ascending Nephritis - Nephria</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Prolonged Cerebral anemia resulting</u> | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>586X</u> | | | | | | |
| | DUE TO (c) <u>from Cardiac Arrest at time of Gallbladder</u> | | | | | | | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour <u>4:15</u> a.m. <u>PM</u> Month <u>Dec</u> Day <u>30</u> Year <u>1957</u> | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE | |
| 21. I attended the deceased from <u>April 19 57</u> to <u>Dec 30 57</u> and last saw her alive on <u>Dec 30, 1957</u> Death occurred at <u>7:15</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <u>Shel A. Tompkins M.D.</u> (Degree or title) | | | | 22b. ADDRESS <u>Crane, Mo</u> | | 22c. DATE SIGNED <u>12-31-57</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>1/2/58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Masonic</u> | | 23d. LOCATION (City, town, or county) (State) <u>Crane Missouri</u> | | | |
| 24. FUNERAL DIRECTOR <u>George H. Manlove</u> Address <u>Crane Mo</u> | | | 25. DATE RECD. BY LOCAL REG. <u>Jan 3 - 1958</u> | | 26. REGISTRAR'S SIGNATURE <u>Mrs. G. Elmer Brown</u> <u>per Lena Murray</u> | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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, ~~only~~, Student Embalmer No.
working under my personal supervision.

Student,
Signature of Student Embalmer

Signed *Gary H. Maulore*

Licensed Embalmer No. *3827*

P. O. Address *Cran 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.