

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 9 1960

=60-026132

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 311

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>CAPE GIRARDEAU</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>CAPE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CAPE GIRARDEAU</b> Length of stay in lb <b>3 WEEKS</b>		c. CITY OR TOWN <b>JACKSON, Mo</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Francis Hosp</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>711 CAPE ROAD</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENKLE</b> Middle <b>J.</b> Last <b>BOWMAN</b>			4. DATE OF DEATH Month <b>7</b> Day <b>29</b> Year <b>60</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/13/1894</b>
9. AGE (last birthday) <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Business Men</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Milling, Mill</b>	11. BIRTHPLACE (City and state or country) <b>Burdettville, Mo</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>		13a. FATHER'S NAME <b>J. R. Bowman</b>	
13b. MOTHER'S MAIDEN NAME <b>Billie Linely</b>		14. NAME OF HUSBAND OR WIFE <b>William Cape</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs Bowman Jackson</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Lympho Sarcoma</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>3-4 wks.</b> <b>4 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Herpes Zoster -</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <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 <b>Jan-1955</b> to <b>7/29-60</b> and last saw him alive on <b>7/28-60 - Pm.</b> Death occurred at <b>4:30 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Milton Shars, M.D.</b>		22b. ADDRESS <b>937 Broadway</b>	
22c. DATE SIGNED <b>7/30-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>7/30/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>JACKSON Mo</b>
24. FUNERAL DIRECTOR ADDRESS <b>McCombs Jackson, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>8-1-1960</b>	26. REGISTRAR'S SIGNATURE <b>Gene Kasten</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bruce "Doehlin"

Licensed Embalmer No. 5097

P. O. Address Jackson, M

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.