

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035998

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4802 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

<b>FILED SEP 18 1963</b>		1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett City Mo</u>		Length of stay in lb <u>1 hour</u>		c. CITY OR TOWN <u>Independence</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 <u>Jackson County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>714 East Hayward</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bora</u> Middle <u>alice</u> Last <u>Bowen</u>			4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1963</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>10-27-1881</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home-Maker</u>		11. BIRTHPLACE (City and state or country) <u>Wakarusa, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Hickman Adkins</u>		13b. MOTHER'S MAIDEN NAME <u>Haney Simpson</u>	
14. NAME OF HUSBAND OR WIFE <u>Ervett Bowen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT <u>Mr Calvin Johnson</u>		Address <u>3517 So. Spring</u> <u>Indep. Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>		DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (c) <u>HYPERTENSION</u>		<u>10 YEARS</u>	
DUE TO (c) <u>HYPERTENSION</u>				<u>15 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <u>DEC. 25, 1962</u> to <u>AUG 27, 1963</u> and last saw her/him alive on <u>AUG 27, 1963</u> Death occurred at <u>8:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Andrew G. Parrish M.D.</u> (Degree or title)		22b. ADDRESS <u>817 DAKOTA, INDEP, MO.</u>		22c. DATE SIGNED <u>8/30/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-30-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u>		23d. LOCATION (City, town, or county) (State) <u>Independence, Mo.</u>	
24. FUNERAL DIRECTOR <u>Roland R. Spake Indep, Mo</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>8-30-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>

USE BLACK INK OR TYPEWRITER RIBBON

**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 Don W. Lindsey

Licensed Embalmer No. 5198

P. O. Address Lindsey, 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.