MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

File No. 25275
Registered No. 41

1. PLACE OF DEATH
County Montcalm Co Registration District No. 571
Township Walker Primary Registration District No. 4335
City California (No. ..... St. ..... Ward)

2. FULL NAME Mary C. Bowman

(a) Residence. No. ..... St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71	5	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Montcalm Co
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Archibald Mendills
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Penn
12. MAIDEN NAME OF MOTHER Nancy Wilson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Penn

14. INFORMANT E M. Bowman
(Address) Jamestown Mo

15. July 21, 1929 Jas. W. Rader
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19 1929

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1929, to July 19, 1929, that I last saw h... alive on July 19, 1929, and that death occurred, on the date stated above, at 4 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
Coma
..... (duration) ..... yrs. 2 mos. ..... ds.
CONTRIBUTORY (SECONDARY) Arterio sclerosis,
..... (duration) 2 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? —
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no. DATE OF —
WAS THERE AN AUTOPSY? no.
WHAT TEST CONFIRMED DIAGNOSIS? Physical exam,

(Signed) L. L. Latham, M. D
, 19 (Address) Calyporia Mo

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: City Cemetary
DATE OF BURIAL: 7/21 1929

20. UNDERTAKER: Holman & Friedmeyer
ADDRESS: California Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD