

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

Do not use this space.

26638

1. PLACE OF DEATH

County.....
Township.....
City **St. Louis Mo.**

Registration District No. **791**
Primary Registration District No. **1003**
St. **St. Johns Hospital**

File No.....
Registered No. **7909**
St. Ward)

2. FULL NAME

Alice Adele Cowan

(a) Residence No. St. **12** Ward. **Burbon Mo.**
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. **3** 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) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct. 10/1920**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
8 **9** **29**

8. OCCUPATION OF DECEASED

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

115A

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Mo.**

10. NAME OF FATHER **Claude J. Cowan**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Burbon**
(STATE OR COUNTRY) **Mo.**

12. MAIDEN NAME OF MOTHER **Grace Alexandra**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Burbon**
(STATE OR COUNTRY) **Mo.**

14. INFORMANT **Claude J. Cowan**
(Address) **Burbon Mo.**

15. FILED **31**, 19**24** **May C Stanley**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 30 1924**

17. I HEREBY CERTIFY, That I attended deceased from **July 30**, 19**24**, to **July 30**, 19**24**, that I last saw her alive on **July 30**, 19**24**, and that death occurred, on the date stated above, at **1:45** **0**...m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Post Operative Shock following removal of tonsils.

CONTRIBUTORY (SECONDARY) **Infected Tonsils, non diphtheritic cause unknown**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **7/30-24**

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **Robert Thylaud**, M.D.

*State the DISEASE CAUSING DEATH, or in 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 **Burbon Mo.** DATE OF BURIAL **8/2 1929**

20. UNDERTAKER **Linstromberg Und.** ADDRESS **Burbon 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.

261

