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

Do not use this space.

File No. 19392

Registered No. 5340

1. PLACE OF DEATH

County..... Registration District No. 791 1003

Township..... Primary Registration District No.....

City St. Louis (No. City Hosp. St. ..... Ward)

1964

2. FULL NAME Irvin R. Rowley

(a) Residence. No. 1417 No. 10th St., ... Ward. 25
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	white	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 3 - 1896

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
35	1	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 2
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER John Rowley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ill.
12. MAIDEN NAME OF MOTHER Jane Doyle
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ill

14. Hospital Information
INFORMANT Peoples Hosp.
(Address) City Hospital

15. FILED ....., 19.....

REGISTRAR Mrs C. J. Farley

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 5th 1931

17. I HEREBY CERTIFY, That I attended deceased from May 2nd, 1931, to May 5th, 1931, that I last saw him alive on May 5th, 1931, and that death occurred, on the date stated above, at 8:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Perforated Duodenal Ulcer and Generalized Peritonitis

1178 (duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (SECONDARY) 1178 (duration) ....yrs. ....mos. ....da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Yes

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 5/1/31

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Operative

(Signed) Carl M. Hoch, M.D.

5/5, 1931 (Address) City Hosp.

*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 Calvary Cemetery — DATE OF BURIAL 5/8 1931

20. UNDERTAKER Arthur J. Donnelly — ADDRESS 2839 Wash St.

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

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.

Q. drawing