

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS SHOULD STATE

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

Do not use this space.

**MAY 31 1937**

1. PLACE OF DEATH  
 90 County St. Louis Registration District No. 790  
 2 Township Wentz Primary Registration District No. 6038  
 7 City St. Louis (No. St. Louis Co. Hosp. 1) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2. FULL NAME Francis Fowler St. Louis County Hospital  
 (a) Residence, No. Chicago Ave Clayton St., Mo 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.

File No. 17599  
 Registered No. 166

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX F 4. COLOR OR RACE caucas 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dommy Fowler  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4/27/15  
 7. AGE YEARS 22 MONTHS 0 DAYS 1 If LESS than 1 day, hrs. min.  
 OCCUPATION Domestic  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fredricks town Mo.  
 MOTHER FATHER 13. NAME Alex Kinder  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 15. MAIDEN NAME Gertude Casey  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 17. INFORMANT Alex Kinder  
 (ADDRESS)  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Resurrection Cent DATE 5/4 1937  
 19. UNDERTAKER (ADDRESS) J. S. Purpus  
W. Webster Brown  
 20. FILED 5/5 1937 Dr. J. Signorilli Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/23/37 19\_\_\_\_  
 22. I HEREBY CERTIFY, That I attended deceased from 4/22 19\_\_\_\_ to 4/23/37 19\_\_\_\_  
 I last saw her alive on 4/23/37 19\_\_\_\_. Death is said to have occurred on the date stated above, at 11:30 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Bilateral Chronic Pulmonary Tuberculosis Date of onset \_\_\_\_\_  
 Other contributory causes of importance: 73  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Clinical Was there an autopsy? No  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) R. J. Allison M. D.  
 (Address) St. Louis County Hosp.

