

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.

OCT 14 1937

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

32511

Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City ST. LOUIS
(e) Length of residence in city or town where death occurred 5 yrs. mos. ds.

Registration District No. 791
Primary Registration District No. 1003
(d) Street No. 3908 LABADIE

Registered No. 8565

(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 3908 LABADIE

(Usual place of abode, if no street address, write county or city)

St. 10 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>FEMALE</u>	4. COLOR OR RACE <u>WHITE</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>WIDOWED</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>DANIEL KENNEDY</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>SEPT. 17 1857</u>		
7. AGE <u>79</u>	YEARS <u>11</u>	MONTHS <u>24</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>AT HOME</u>		9. Industry or business in which work was done, as 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) <u>ILL.</u>		
13. NAME <u>DANIEL BOWES</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>N.Y.</u>		
15. MAIDEN NAME <u>ADELINE BOUCHARD</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>MICHIGAN</u>		
17. INFORMANT (ADDRESS) <u>Mr. J. A. Halton 7028 Stanley Ave</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>PACIFIC MO</u> DATE <u>SEPT 13th 1937</u>		
19. FUNERAL DIRECTOR (ADDRESS) <u>LAWRENCE MULLEN 5165 DELMAR BLVD</u>		
20. FILED <u>SEP 12 1937</u> <u>J. H. Bredeck</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) SEPT. 11 1937

22. I HEREBY CERTIFY, That I attended deceased from 10-31-37 to 9-11-37

I last saw her alive on 2-27-37 1937 Death is said to have occurred on the date stated above, at 11 A.M.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage

Arterio Sclerosis

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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) Carl Keys M. D.

(Address) 3708 Washington

STATEMENT BY LICENSED EMBALMER

I, Howard F Rowland, Licensed Embalmer No. 3114
hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself
..... L. E.
No. or by, Registered Apprentice No.
working under my personal supervision.

Signed Howard F Rowland
Licensed Embalmer No. 3114

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.)