

REC'D AUG 11 1939 791  
Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

1003

(a) County \_\_\_\_\_  
(b) City or town St. Louis.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Jewish Hospital.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 73 Years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Maggie Scott Cowen. 500

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed.

6. (b) Name of husband or wife Frank A. Cowen. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 31, 1866.  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>5</u>	<u>18</u>	hr. _____ min.

9. Birthplace St. Louis, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home.

11. Industry or business \_\_\_\_\_

12. Name Soloman Scott.

13. Birthplace Chestertown, Maryland.  
(City, town, or county) (State or foreign country)

14. Maiden name Maggie Ford.

15. Birthplace New York,  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Marquerite Cowen

(b) Address 5848 Cabanne

17. (a) Burial (b) Date thereof 7-21-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 5840 Lindell Blvd

19. (a) JUL 20 1939 (b) J. T. Bradick  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis. 5  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5848 Cabanne Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19  
year 1939 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from May 15, 1939  
19 \_\_\_\_\_, to July 19, 1939  
that I last saw him alive on July 19, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 2 days

Due to Cerebral arterio sclerosis 3 yrs  
Pseudo tubercular pneumonia 20 yrs

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 1

23. Signature Louis L. Tureen (M. D. or other) MD  
Address 3700 Washington Date signed 7/21/39

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.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.)**

**If this body is not embalmed, above space should be left blank.**