DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 739

Registration District No. 7917 Primary Registration District No. 1003 Registrar's No. 739

1. PLACE OF DEATH:

(a) County FILED FEB 1 1940

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Josephine Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 3wks. (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County

(c) City or town ST. LOUIS 18
(If outside city or town limits, write "RURAL")

(d) Street No. 3504 Vista Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Harry Dowling 452

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Elizabeth Dowling

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased November (Month) 7 (Day) 1864 (Year)

8. AGE: Years 75 Months 2 Days 16 If less than one day hr. min.

9. Birthplace Liverpool (City, town, or county) England (State or foreign country)

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name Peter Dowling
13. Birthplace (City, town, or county) England (State or foreign country)

MOTHER
14. Maiden name Mary Unk
15. Birthplace (City, town, or county) England (State or foreign country)

16. (a) Informant's own signature Elizabeth Dowling
(b) Address 3504 Vista Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/40 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peter's Cem.

18. (a) Signature of funeral director E. J. Schnur
(b) Address E. J. Schnur 3125 Lafayette Ave.

19. (a) JAN 25 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 23 year 1940 hour 5:30 minute P M.

21. I hereby certify that I attended the deceased from 1935, to Jan 23, 1940 that I last saw him alive on 1/23/ 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Locomotor Ataxia	18 yrs
Due to Infection of bladder & kidneys (Cystitis & Pyelitis)	5 yrs 10 days
Due to Cystitis { non catarrhal, non gonococcic, non tubercular	
Other conditions (Include pregnancy within 3 months of death) Pyelitis non Calculous	
Major findings: Of operations No Kidney stones	
Of autopsy X	

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) Nil
(b) Date of occurrence X
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? X (Specify type of place)
While at work? X (e) Means of injury X

23. Signature B. Franklin (M. D. or other)
Address 514 S. Jefferson Ave Date signed 1/25/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

REV. 3-17-39 I X19511

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 Jos R Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 La Fayette Ave

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.