

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16167

State File No. _____

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 733

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility **3**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 2009 So. First St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13
year 1940 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from April 11,
1940, to April 13, 1940
that I last saw him alive on April 13, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral neoplasm,
right frontal region
Type uncertain

Duration
unknown

Due to _____
Due to 55 d

Other conditions None
(Include pregnancy within 3 months of death)

PHYSICIAN
Underline
the cause to
which death
should be
charged sta-
tistically.

Major findings:
Of operations None
Of autopsy See cause of death

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)
(c) Means of injury _____

23. Signature C. W. HUGHES, M. D., Chief (M. D. or other) _____
Address Med. Officer, Vet. Adm. Fac. Date signed _____

8. (a) PRINT FULL NAME Robert F. BOWLES **420**

3. (b) If veteran, name war World 8. (c) Social Security No. Unknown

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 30, 1900
(Month) (Day) (Year)

8. AGE: Years 39 Months 10 Days 13
If less than one day _____ hr. _____ min.

9. Birthplace Springfield, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business _____

12. Name Walter C. Bowles

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

14. Maiden name Virginia (?)

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

16. (a) Informant Chief, Vet. Adm. Facility
(b) Address Jefferson Barracks, Mo.

17. (a) ~~REMOVED~~ (b) Date thereof APRIL 15 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SPRINGFIELD ILLINOIS
(d) Signature of funeral director W. H. Miller H. L. Co.
(e) Address 78 1/2 S. 1st St. Springfield, Mo.
(f) Date received local registrar APR 15 1940
(g) Registrar's signature C. W. Hughes

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.