

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **19423**
5619
 Registrar's No.

FILED JUN 30 1943
 Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town **St. Louis Mo.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Enroute City Hospital # 1 3
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community **About 27 Years** (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME **Jessie Bowman**

3. (b) If veteran, name war **#1** 3. (c) Social Security No. **311-20-8133**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Gertrude Bowman** 6. (c) Age of husband or wife if alive **51** years
 7. Birth date of deceased **5 14 1894**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 0 3 hr. min.

9. Birthplace **Louisville Kentucky**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Waiter**

11. Industry or business

MOTHER FATHER { 12. Name **Eli Bowman**
 13. Birthplace **Henryville Ind.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Sarah Jane Burk**
 15. Birthplace **Henryville Ind.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Gertrude Bowman**

(b) Address **1722 N. 13th St.**

17: (a) **Burial** (b) Date thereof **6 21 43**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem**

18. (a) Signature of funeral director **Goodhart & Goodhart**

(b) Address **2228 St Louis Ave.**

19. (a) **JUN 30 1943** (b) **J. F. Buddeck**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County.....
 (c) City or town **St Louis Mo.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **1021a Franklin Ave**
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **17**
 year **43** hour **5** minute **30** p.m.

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

Immediate cause of death..... Duration.....

Cerebral Apoplexy (right)
 Due to.....

Due to.....

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations.....

Of autopsy.....

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)
 (c) Means of injury.....

23. Signature **W. H. H. H. H. H.** (M.D. or other)
 Date signed **6/20/43**

JUN 30 1966

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, fact should be so stated above.