

FILED JUN 19 1943 318
Registration District No.

Primary Registration District No. 1003

Registrar's No. 5331

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **Saint Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4533 Westminster /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town..... **Saint Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4533 Westminster**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... **CAROLINE L. FOWLER**

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

4. Sex **Female** 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..... **Feb. 28, 1874**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 3 11 hr. min.

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

10. Usual occupation..... **Bookkeeper**

11. Industry or business.....

12. Name..... **Frederick A. Fowler**

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

14. Maiden name..... **Genevieve Hagen**

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

16. (a) Informant..... **Mrs. Katherine Jones**

(b) Address..... **4533 Westminster**

17. (a) **Cremation** (b) Date thereof **June 11, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... **Missouri Crematory**

18. (a) Signature of funeral director..... **Craig Mortuary**

(b) Address..... **4468 Washington**

19. (a) **JUN 10 1943** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **9**
year **43** hour **20** minute M.

21. I hereby certify that I attended the deceased from **6-1-43** 19... to **6-9-43** 19...
that I last saw him **2** alive on **6-9-43** 19...
and that death occurred on the date and hour stated above.

Immediate cause of death..... **Cordis Decomposition**

Due to **no correct cause**

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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.....

23. Signature..... **[Signature]** (M. D. or other) **[Signature]**
Address **5932 m. g. court** Date signed **6/10/43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

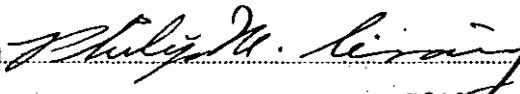
STATEMENT BY LICENSED EMBALMER

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

NO EMBALMING

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....



Licensed Embalmer No..... 3284.....

P. O. Address..... 4468 Washington.....

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.