

FILED JAN 3 1944
Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(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:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Katherine Bowen**

3. (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 **Eugene Bowen**
6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased. **Aug. 20 10 1865**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 4 8 hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business.....

12. Name **John Roehr**

13. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Katherine Strodtman**

15. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Goodsamaritan Home**

(b) Address **4500 Washington Ave**

17. (a) **Burial** (b) Date thereof **12-20-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Cem.**

18. (a) Signature of funeral director **Drehmann-Harral**

(b) Address **1905 Union Blvd**

19. (a) **DEC 20 1943** (b) **J. F. Bruders**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4500 Washington Ave.**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **18**
year **1943** hour **9** minute **30 A.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 **Fracture right leg** Duration
arteries sclerotic, suffered when
she fell to the floor in doorway
of Good Samaritan Home
Oct 13 1943, exact time
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) **accident**
(b) Date of occurrence **Oct 13 1943**
(c) Where did injury occur? **St. Louis 000**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
1 home

While at work?..... (Specify type of place)
Means of injury **fall**

3. Signature **W. J. Bruders** (M. D. or other)
Address **Deaconess Hospital** Date signed **12/20/43**

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.....

Albert W. Thompson Jr

Licensed Embalmer No.....

4237

P. O. Address.....

St. Louis

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.