

FILED FEB 27 1944 318
Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 426

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:
Shriners' Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 1/2 Mos. (Specify whether)
In this community Same
years, months or days)

3. (a) PRINT FULL NAME Dorothy Lucille Mowrey

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

4. Sex ♀ 5. Color or race W 6. (a) Single, widowed, married, divorced 50

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

7. Birth date of deceased July 1 1928
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
15 6 13 hr. min.

9. Birthplace Sparta, Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business _____

MOTHER FATHER
12. Name H.F. Mowrey
13. Birthplace Claremont Ill. 1 (City, town, or county) (State or foreign country)
14. Maiden name Madge Downs
15. Birthplace Seymour Ind. 1 (City, town, or county) (State or foreign country)

16. (a) Informant H.F. Mowrey

(b) Address SPARTA, ILL.

17. (a) Removal (b) Date thereof 1-15-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sparta, Illinois

18. (e) Signature of funeral director Albert H. Hoppe, Inc

(b) Address 4700 Washington Blvd.

19. (a) JAN 14 1944 (b) J. F. Biduch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill. (b) County RANDOLPH
(c) City or town SPARTA 0
(If outside city or town limits, write "RURAL")
(d) Street No. 363 First. (If rural, give location) NR.
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14
year 1944 hour 4 minutes 35 A. M.

21. I hereby certify that I attended the deceased from September 29, 1943, to Jan 14, 1944
that I last saw h.e.v. alive on Jan 14, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Respiratory + Circulatory Collapse Duration

Due to TETANUS 7 days

Other conditions Idiopathic Scoliosis
(Include pregnancy within 3 months of death)

Major findings: Corrected Spinal Curvature
Of operations _____
Of autopsy Not done

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? _____
(Specify type of place) _____
While at work? (e) Means of injury 0

23. Signature C. N. Cregar (M. D. or other) M.D.
Address 710 S. Kings Highway Date signed 1-14-44

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

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

John W. Gonwaki

Licensed Embalmer No. *3398*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.