

No. 2
-2-43
17-39
X35697

FILED JUN 9 1944 18

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 5035

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: Homer Phillips 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 Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1533^e Carr St (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: Joyce Marie Rowell

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

4. Sex F 5. Color or Race CP1 6. (a) Single, widowed, married, divorced U
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 2nd 1940
(Month) (Day) (Year)

8. AGE: Years 3 Months 8 Days 27 If less than one day hr. min.

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

10. Usual occupation Child

11. Industry or business _____

MOTHER FATHER { 12. Name Walter Rowell
13. Birthplace St Louis MO
(City, town, or county) (State or foreign country)
14. Maiden name MAMIE SMILEY
15. Birthplace Century Florida
(City, town, or county) (State or foreign country)

16. (a) Informant Walter A. Rowell, Jr
(b) Address 1533^e Carr Str

17. (a) burial (b) Date thereof 6-2-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director W. Kandle Dixon
(b) Address 3133 Bell ave

19. (a) JUN 1 1944 (b) J. Z. Pradeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
year 44 hour 4:30 minute 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 _____

Due to Status Thymico

Due to Lymphaticae

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) (e) Means of Injury _____

23. Signature Alfred Perry (M. D. or other)
Address Deputy Coroner Date signed 5/31/44

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.....

.....
working under my personal supervision.

....., Registered Apprentice No.....

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.