

FILED JAN 15 1945 318

Registration District No.

Primary Registration District No.

1003

Registrar's No.

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:
Isolation Hospital.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8/18/44 to
12/26/44 (Specify whether
 In this community 12/26/44
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County.....
 (c) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. 2021 Cole.
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 26th
 year 1944 hour 10 minute 25 P. M.
 21. I hereby certify that I attended the deceased from 8/18
1944, 19 , to 12/26, 1944
 that I last saw her alive on 12/26, 1944
 and that death occurred on the date and hour stated above.
 Immediate cause of death pulmonary tuberculosis Duration 5.4.10

3. (a) PRINT FULL NAME Grace Bowen.

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

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased Jan 10th 1924
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>20</u>	<u>11</u>	<u>16</u>	<u> </u> hr. <u> </u> min.

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

10. Usual occupation Housewife.

11. Industry or business.....

12. Name Ben Bowen.

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

14. Maiden name Ida Collins.

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

16. (a) Informant Stella Grady

(b) Address Isolation Hospital

17. (a) Burial (b) Date thereof 1-8-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director J. Ryan

(b) Address 5700 Arsenal

19. (a) JAN 5 1945 J. P. Brebeck
(Date received local registrar) (Registrar's Signature)

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?
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature J. P. Brebeck (M. D. or other) MD.

Address 5600 Arsenal St. Date signed 12-27-44

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.....

....., 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.

Registration District No. 378 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Grace Bauer
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive unk
7. Birth date of deceased Jan 10 (Month) (Day) (Year)

8. AGE: Years 20 Months 11 Days _____ Unless than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) JAN 19 1945 (b) J. J. Bredeek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (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 4 year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her _____ above on _____ 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

1-533
SUPPLEMENTARY

39178