

FILED DEC 21 1945

Registration District No. _____

Primary Registration District No. **1002**

Registrar's No. _____

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 G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **16 days**
In this community _____
(Specify whether 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. **3412 Washington**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Ferdinand Fowler**

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

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced, **Widowed**
6. (b) Name of husband or wife **Son** 6. (c) Age of husband or wife if alive **64** years
7. Birth date of deceased **Feb. 28 1881**
(Month) (Day) (Year)

8. AGE: Years **64** Months **9** Days **12** If less than one day hr. _____ min. _____

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

10. Usual occupation **Labor**

11. Industry or business _____

12. Name **Lewis Fowler**
13. Birthplace **Memphis Tenn.**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Caspou**
15. Birthplace **Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lewis Fowler**
(b) Address **4435 A. Easton**

17. (a) **Walter** (b) Date thereof **Dec. 8, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Petosis Mo.**

18. (a) Signature of funeral director **Dement & Son**

(b) Address **2629 Cole St**

19. (a) **DEC 8 1945** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **6**
year **1945** hour **5** minute **20 A.** M.

21. I hereby certify that I attended the deceased from **11-20-** 1945, to **12-6** 1945;
that I last saw him alive on **12-6** 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Thrombosis**

Due to _____

Due to _____

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **No**

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 **B. W. Phillips** (M. D. or other) _____

Address **22601 N Whittier** Date signed **12/6**

Duration **1 Wk**

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

Signed: N. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.