

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

42362

Registration District No.

Primary Registration District No.

Registrar's No.

2932

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town KOCH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ROBT. KOCH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 111 DAYS
(Specify whether
In this community 15 YRS
years, months or days)

3. (a) PRINT FULL NAME BOWMAN, MILDRED LEE

3. (b) If veteran, name war - 3. (c) Social Security No. NONE

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife ILIS BOWMAN 6. (c) Age of husband or wife if alive 33 years
7. Birth date of deceased JULY 24 1914
(Month) (Day) (Year)

8. AGE: Years 31 Months 5 Days 0 If less than one day
hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name FRANK CHAPMAN
13. Birthplace - MISSOURI
(City, town, or county) (State or foreign country)
14. Maiden name LIZA CRUM
15. Birthplace - MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant HOSPITAL RECORDS

(b) Address ROBT. KOCH HOSPITAL

17. (a) Removal (b) Date thereof 12/27/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 1111 Anutt Mo.

18. (a) Signature of funeral director Stroet - Carroll

(b) Address 4800 Natural Bridge Ave

19. (a) 12-28-45 (b) Ed. M. Duran
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST. LOUIS
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 2518 N. 21ST. ST.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 24
year 1945 hour 2 minute 40 P.M.

21. I hereby certify that I attended the deceased from SEPT. 4
1945, to DEC. 24, 1945

that I last saw HER alive on DEC 24, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death CHRONIC PULMONARY TUBERCULOSIS 1 1/2 yrs

Due to 13 D

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?

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

23. Signature Bernard Friedman (M. D. or other) M.D.
Address ROBT. KOCH HOSPITAL Date signed 12-29-45

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.