S. N
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 4 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7022

Registration District No. 317 Primary Registration District No. 2002 Registrar's No. 508

1. PLACE OF DEATH:

(a) County ST. LOUIS:

(b) City or town UNIVERSITY CITY: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: RESIDENCE (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI: (b) County ST. LOUIS: 96

(c) City or town UNIVERSITY CITY: 3 (If outside city or town limits, write "RURAL")

(d) Street No. 715 WEST GATE AVE. 5 (If rural, give location)

(e) Citizen of foreign country? NO. 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MARY KATHERINE FOWLER

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOW

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

7. Birth date of deceased OCTOBER (Month) 12 (Day) 1862 (Year)

8. AGE: Years 83 Months 4 Days 13 If less than one day hr. min.

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

10. Usual occupation AT HOME

11. Industry or business

FATHER
12. Name WILLIAM LESTER
13. Birthplace (City, town, or county) VIRGINIA (State or foreign country)

MOTHER
14. Maiden name BEBECCA ANN WILLS
15. Birthplace (City, town, or county) VIRGINIA (State or foreign country)

16. (a) Informant HENRIETTA FOWLER

(b) Address 715 WEST GATE AVE.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 28/46 (Month) (Day) (Year)

(c) Place: burial or cremation Waco, Texas.

18. (a) Signature of funeral director C. R. LUPTON & SONS

(b) Address 7233 DELMAR BLVD.

19. (a) 2-28-46 (Date received local registrar) (b) E. D. McGovern MD (Registrar's signature) MSG

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25 year 1946 hour 3 minute 30 P M.

21. I hereby certify that I attended the deceased from 10-13, 1945 to 2-25, 1946 that I last saw her alive on Feb 16, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	2 days
Due to Carcinoma of Cecum	
Intertrochanteric fracture	
Due to Lgt Femur	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) 134

(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 Kevin Kosing (M. D. or other) MD

Address 3720 Washington Date signed 2/26/46

(Licensed Embalmer's Statement on Reverse Side)

DR. CARL KOENIG

Carl S. Koenig
3720 Washington
JE 3477
1:30 - 5

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 Don Paul Marler, Registered Apprentice No. 381, working under my personal supervision.

Signed Bradford A. Miles

Licensed Embalmer No. 2901

P. O. Address University City

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.

S. No. 2B
5M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Mar

Registration District No. 317 Primary Registration District No. 2002 Registrar's No. 508

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

5973

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town University city
(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)

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

3. (a) PRINT FULL NAME Mary K. Fowler

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct (Month) 12 (Day) 1862 (Year)

8. AGE: Years 83 Months 4 Days 10 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive 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)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

SUPPLEMENTARY

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident Jan 16th

(b) Date of occurrence Jan 16th 1940

(c) Where did injury occur? At Home (City or town) St Louis (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? At Home
(Specify type of place)

While at work? (e) Means of injury Fell while going to bathroom

23. Signature Kors Koenig (M. D. or other) MS

Address 3 W Washington Date signed 3/8/46

7022