

FILED JUL 22 1946
Registration District No. 317

Primary Registration District No. 6076

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

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: Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 52 days
(Specify whether for years, months or days)

In this community 56 yrs 1 mo, 49 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1316 a Franklin
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Harry F. Bowler

3. (b) If veteran, name war no.

3. (c) Social Security No. ?

20. DATE OF DEATH: Month July day 8
year 1946 hour 5 minute 15 P.M.

21. I hereby certify that I attended the deceased from May 17
1946 to July 8, 1946
that I last saw him alive on July 6, 1946
and that death occurred on the date and hour stated above.

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased May 20 1890
(Month) (Day) (Year)

Immediate cause of death
Chronic Pulmonary Tuberculosis

Due to _____

Due to 1316

Other conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

8. AGE: Years 56 Months 1 Days 49 If less than one day hr. _____ min. _____

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

10. Usual occupation Porter

11. Industry or business ?

Major findings: Of operations _____

Of autopsy Chronic Pulmonary Tuberculosis

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name William Bowler

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

14. Maiden name Johanna C. Berger

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

16. (a) Informant Hospital Record
(b) Address Koch Hospital

17. (a) BURIAL (b) Date thereof July 11 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cafedry Cem.

18. (a) Signature of funeral director E. J. Dehn
(b) Address 3125 Lafayette Ave.

19. (a) 7-12-46 (b) Edm. Gerant
(Date received local registrar) (Registrar's signature)

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 Charles Silverberg (M.D. or other) M.D.
Address Koch Hospital Date signed 7/9/46

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.....

Joseph B. Vollmer

Licensed Embalmer No. *4014*

P. O. Address *St Louis, Mo*

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.