No. 2
-12-45
-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 30 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31289

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 1907

1. PLACE OF DEATH:

(a) County St Louis County
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 4 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 96
(c) City or town Kirkwood
(If outside city or town limits, write "RURAL")
(d) Street No. 243 W Argonne
(If rural, give location)
(e) Citizen of foreign country? (~~Yes or~~ No)
If yes, name country

3. (a) PRINT FULL NAME Stowe, Henry

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

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 5 (Month) 30 (Day) 1869 (Year)

8. AGE: Years 77 Months 3 Days ~~18~~ If less than one day hr. min.

9. Birthplace Cleveland Ohio
(City, town, or county) (State or foreign country)
10. Usual occupation None
11. Industry or business None

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

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

16. (a) Informant Allen Stowe, Son
(b) Address 243 W Argonne Kirkwood
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-46 (Month) (Day) (Year)
(c) Place: burial or cremation St Johns Cem - Manchester
18. (a) Signature of funeral director Louis H Bapp Inc
(b) Address Kirkwood Mo
19. (a) 9-19-46 (Date received local registrar) (b) Ruth J Allen MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 17 year 1946 hour 12 minute 20 P.M.

21. I hereby certify that I attended the deceased from 9-13, 1946 to 9-17, 1946 that I last saw him alive on 9-17-, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic generalized c̄ right cerebral thrombosis

Due to 83 h

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.

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 [signature] (M. D. or other) MD
Address 60 Brentwood Blvd ~~Date signed~~

(Licensed Embalmer's Statement on Reverse Side)

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.....Felix Durand.....

Licensed Embalmer No.....3034.....

P. O. Address.....Kirkwood (22)

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.