

No. 2
5-17-39
238671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19570

FILED JUN 18 1947

State File No.

Registrar's No. 1139

Registration District No. 37

Primary Registration District No. 3063

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

1. PLACE OF DEATH:

(a) County St. Louis County

(b) City or town Clanton, Mo.
(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 6 1/2 Days
(Specify whether)

In this community 12 years
years, months or days

3. (a) PRINT FULL NAME Martin Sowers

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 wid.

6. (b) Name of husband or wife Alice Sowers

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

7. Birth date of deceased 12 - 27 - 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>5</u>	<u>11</u>	hr. min.

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

10. Usual occupation Pipe Bender

11. Industry or business _____

MOTHER FATHER

12. Name Bentley Sowers

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

14. Maiden name Rendelmann

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

16. (a) Informant Dau - Mrs. J. D. Hughes

(b) Address Glencoe, Mo.

17. (a) REMOVAL (Burial, cremation, or removal) DONGOLA, ILL.

(b) Date thereof 6/18/47
(Month) (Day) (Year)

(c) Place: burial or cremation DONGOLA, ILL.

18. (a) Signature of funeral director SCHRADER FUNERAL HOME

(b) Address BALLWIN, MO.

19. (a) 6-10-47 (Date received local registrar)

(b) Bentley Sowers (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri

(b) County St. Louis Co. 96

(c) City or town Glencoe
(If outside city or town limits, write "RURAL")

(d) Street No. Route one
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7th
year 1947 hour 1 minute 2 M.

21. I hereby certify that I attended the deceased from June 1st, 1947 to June 7th, 1947
that I last saw him alive on June 7th, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral vascular accident Duration 8 days

Due to Hypertensive cardiac-vascular disease

Due to _____

Other conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: 131-0

Of operations _____

Of autopsy generalized arteriosclerosis, hypertrophy & dilatation of heart, arteriosclerotic nephrosclerosis, bronchopneumonia

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)

(c) Means of injury _____

23. Signature Wm. J. Joffe MD (M. D. or other)

Address 601 Brentwood Blvd. Clay Date signed 6-7-47

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 *Fico. Sprader*
Licensed Embalmer No. *3066*
P. O. Address *Ballwin, 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.

Registration District No. 317

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St Louis Co.

(b) City or town Clayton
(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

3. (a) PRINT FULL NAME Martin Souren

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased See 27
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 24 (If less than one day) _____

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

10. Usual occupation Retired Pine Bender

11. Industry or business Midwest Pine & Supply, St. Louis, Mo.

MOTHER FATHER { 12. Name _____

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

{ 14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
year 1956 minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him 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: St. Louis, Mo.

Of operations _____

Of autopsy _____

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)
(c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SLIPPLENENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

5-169570