

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27652
Registrar's No. 7035

FILED AUG 23 1948
Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4493 Penrose St.,
(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days

3. (a) PRINT FULL NAME Venies Mary Dowl

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Albert B. Dowl

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Oct. 4th, 1897
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
50	10	5	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Albert B. Dowl

(b) Address 4493 Penrose St.

17. (a) Burial (b) Date thereof 8/12/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kraeger-Voss, Inc.

(b) Address 3402 N. Kingshighway

19. (a) AUG 11 1948 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

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

(d) Street No. 4493 Penrose St.
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th
year 1948 hour 2 minute 20 P. M.

21. I hereby certify that I attended the deceased from May - 47
Aug 1948 to _____ 19____;

that I last saw her alive on July _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____

Due to Cancer of Colon-Primary

Due to Cancer of Ovary

Other conditions 1/6
(Include pregnancy within 3 months of death)

Major findings: Cancer of Colon
Cancer of Ovary
Fract. R. H. Hip

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 J. Thompson (M. D. or other) _____
Address 4932 Maryland Date signed 8-10-48

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

Robert M. Murray

Licensed Embalmer No. *3749*

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.