

No. 300
-10-49
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

30748

State File No.

FILED OCT 13 1948
510

Registrar's No. 195

Registration District No.

Primary Registration District No. 6051

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

1. PLACE OF DEATH:

(a) County St. Charles

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

(c) Name of hospital or institution:
St. Charles County Home 5
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks
(Specify whether years, months or days)

In this community _____
years, months or days

3: (a) PRINT FULL NAME Chris Bowles

3. (b) If veteran, name war NIL

3. (c) Social Security No. NIL

4. Sex Male 5. Color or race black

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: unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

about 74 hr. min.

9. Birthplace Old Monroe Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farm laborer

11. Industry or business _____

MOTHER FATHER

12. Name Andrew Bowles

13. Birthplace Old Monroe Missouri
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace Old Monroe Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Tom Hayden

(b) Address O'Fallon, Missouri

17. (a) burial (b) Date thereof Oct 4-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Paul, Mo.

18. (a) Signature of funeral director H. O. Dallmeyer + Son

(b) Address 800 N. 2nd-St. Charles, Mo.

19. (a) 10-4-48 (b) Fannie Hamilton
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles

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

(d) Street No. 911 North Sixth
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1
year 1948 hour 3:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from Sept 10th 1948 to Oct 1st 1948.
that I last saw him alive on Sept 29th 1948.
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____

Due to Broken compensation
Gen. Arterio-sclerosis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 956

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 A. Perich Schuly MD M.D. or other _____

Address St Charles Mo. Date signed 10/1/48

DATE FILED
OCT 9 1948
DISTRICT OF COLUMBIA
REGISTERED

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 F. Linder
Licensed Embalmer No. 4189
P. O. Address St. Charles 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. 310

Primary Registration District No. 6051

Registrar's No. 195-

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town Rural
(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 Chris Bowler

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

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

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

7. Birth date of deceased unk (Month) (Day) (Year)

8. AGE: all 74 Years Months Days If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-4-48 (b) Francis Hamilton (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 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

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 _____

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-30748