

FILED MAY 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18001
Registrar's No. 1280

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 1222 Bayard 0	

3. NAME OF DECEASED (Type or Print) Georgia Bowen		4. DATE OF DEATH (Month) (Day) (Year) May 8 1950	
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /	8. DATE OF BIRTH Dec. 31, 1910
9. AGE (In years last birthday) 39		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) New Orleans, La.,
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Horace Bowen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No	16. SOCIAL SECURITY NO. 490-26-1369	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Minnie Wilmer 1222 Bayard

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes Mellitus DUE TO (c) None		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		None	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 2129
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-5, 19 50, to 5-8, 19 50, that I last saw the deceased alive on 5-8, 19 50, and that death occurred at 5:15a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James J. Hedrick M. D.	23b. ADDRESS 2601 N. Whittier St	23c. DATE SIGNED 5-9-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-13-50	24c. NAME OF CEMETERY OR CREMATORY Washington Park
		24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.,

DATE REC'D BY LOCAL REG. MAY 12 1950	REGISTRAR'S SIGNATURE J. B. Swater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. B. Hoane 1221 N. Grand
---	---------------------------------------	---

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Lawrence C. ...

Signed
Student Embalmer

Licensed Embalmer No. 4755

P. O. Address _____

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.