.S. No. 300
v. 10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17782

State File No.

FILED JUN 6 1952

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4770

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. John's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2-0669
d. STREET ADDRESS (If rural, give location): 5042 Lotus

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): Katherine
c. (Last): Bowe

4. DATE OF DEATH (Month) (Day) (Year): May 22, 1952

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: May 18, 1952
9. AGE (In years last birthday): If under 1 year: Months / Days: 4 / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Thomas Bowe
13b. MOTHER'S MAIDEN NAME: Margaret Maschek
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Thomas Bowe, 5042 Lotus Ave.
ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Resp failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchopneumonia — 24 hrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Erythroblastosis Fetalis — 4 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 7630

22. *I hereby certify that I attended the deceased from* May 18, 19 52, *to* May 22, 19 52, *that I last saw the deceased alive on* May 22, 19 52, *and that death occurred at* 11 a m., *from the causes and on the date stated above.*

23a. SIGNATURE Leroy Geyshman (Degree or title)
23b. ADDRESS 3708 Iowa
23c. DATE SIGNED May 23-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 5-23-52
24c. NAME OF CEMETERY OR CREMATORY: Calvary
24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL REG.: MAY 23 1952
REGISTRAR'S SIGNATURE: J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Harrigan-Sheahan, 4700 Washington
(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.....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed.....
Licensed Embalmer No.....
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.