

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7759

State File No. ....

BIRTH NO. FILED MAR 22 1954 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 297

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>life</u>	c. CITY OR TOWN <u>St. Joseph</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hospital</u>			e. STREET ADDRESS (If rural, give location) <u>2625 Sacramento St. 01170</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Atha</u> b. (Middle) <u>Bowling</u> c. (Last) <u>Bowling</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 13, 1954</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 16, 1886</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>        </u> Days <u>        </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Joseph, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Michael Kennedy</u>		13b. MOTHER'S MAIDEN NAME <u>Mammie Miller</u>		14. NAME OF HUSBAND/OR WIFE <u>Walter R.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Walter Bowling, 2625 Sacramento St. St. Joseph, Mo.</u>		

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Anterior myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>arteriosclerotic heart disease</u>			<u>4 plus years</u>
		DUE TO (c) <u>leaving from previous myocardial infarction</u>			<u>4-200</u>
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)		
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 3-11, 1954, to 3-13, 1954, that I last saw the deceased alive on 3-12, 1954 and that death occurred at 12:49 PM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Lucien St. John M.D.</u>		23b. ADDRESS <u>902 Edwards St. St. Joseph, Mo.</u>		23c. DATE SIGNED <u>3-15-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>3/15/1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Mar 17 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Heston Bowman</u> ADDRESS <u>St. Joseph, Mo.</u>	

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

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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.....  
Signature of Student Embalmer

Signed.....  
*James P. Hawkins*

Licensed Embalmer No. 45

P. O. Address 317 E 10<sup>th</sup>

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.