

FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14031

State File No. 3607

BIRTH NO. 26712-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3607

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, Mo.		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis (12) 2059 d. STREET ADDRESS (If rural, give location) 5 5788 Westminister 0	
3. NAME OF DECEASED (Type or Print) a. (First) PATRICK b. (Middle) CARL c. (Last) Rowley		4. DATE OF DEATH (Month) (Day) (Year) 3 - 17 - 54	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 3-17-54
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Missouri (U.S.A.)
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William D. Rowley		13b. MOTHER'S MAIDEN NAME MARY Lucille Meeker	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS William D. Rowley 5788 Westminister
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis INTERVAL BETWEEN ONSET AND DEATH 5 hr ANTECEDENT CAUSES DUE TO (b) Premature Birth. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 762.5			
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 3-17, 1954, to 3-17, 1954, that I last saw the deceased alive on 3-17, 1954, and that death occurred at 8:20 P.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Robert Swisher MD		23b. ADDRESS 402 S. Brentwood Bldg. 5	
23c. DATE SIGNED 3-25-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) 4-30-54		24b. DATE	
24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. APR 21 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS 4104 Manchester	

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.....

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.