

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35316

State File No.

89611

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's 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 town or township) St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If rural, give location) 5869 Wabada Ave.		2069			
3. NAME OF DECEASED a. (First) Herman		b. (Middle) A.		c. (Last) Dowling			
4. DATE OF DEATH (Month) (Day) (Year) Oct. 1, 1954		5. SEX Male		6. COLOR OR RACE White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH March 9, 1885		9. AGE (In years last birthday) 69			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paint Mfg. Co.		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (City and State or Foreign Country) Humboldt, Tenn.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Thomas J. Dowling		13b. MOTHER'S MAIDEN NAME Dellie Stovall			
14. NAME OF HUSBAND OR WIFE Clotilde Dowling		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) None		16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT'S SIGNATURE OR NAME H. Edward Dowling		ADDRESS 5869 Wabada Ave.					
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) <i>Diffuse purulent peritonitis</i> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <i>Perforated diverticulitis of sigmoid colon</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3-4 weeks</i> <i>2 months</i>	
19a. DATE OF OPERATION <i>17 Aug 54</i>		19b. MAJOR FINDINGS OF OPERATION <i>Perforated diverticulitis of sigmoid &amp; abscess formation</i>				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) <i>572.1</i>			
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 <i>1 Sept</i> , 1954, to <i>1 Oct</i> , 1954, that I last saw the deceased alive on <i>1 Oct</i> , 1954, and that death occurred at <i>11:30A</i> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>Joseph A. Roy, M.D.</i>		23b. ADDRESS <i>3720 Washington Blvd, St Louis Mo</i>		23c. DATE SIGNED <i>2 Oct 54</i>			
24a. BURIAL/CREMA-TION, REMOVAL (Specify) Removal		24b. DATE <i>10/3/54</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Catholic Cemetery</i>			
24d. LOCATION (City, town, or county) (State) <i>Vincennes, Indiana</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Carl Smith, M.D.</i>		ADDRESS <i>PROVOST UND. CO., 3710 No. Grand Bl.</i>			
DATE REC'D BY LOCAL REG. <i>OCT 4 1954</i>		REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>PROVOST UND. CO., 3710 No. Grand Bl.</i>			

(Licensed Embalmer's Statement on Reverse Side)

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

*Stanley H. Dixon*

Licensed Embalmer No. *4193*

P. O. Address. *St. L.*

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

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