

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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 OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		e. STREET ADDRESS (If rural, give location) 23 1522 Menard	

3. NAME OF DECEASED (Type or Print) a. (First) ROBERT b. (Middle) c. (Last) BOWLIN			4. DATE OF DEATH (Month) (Day) (Year) 8 14 1955		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH 12-22-1870		9. AGE (In years last birthday) 84		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and State or Foreign Country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Sim Bowlin		13b. MOTHER'S MAIDEN NAME Lila Unknown		14. NAME OF HUSBAND OR WIFE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Samuel Bowlin, 9 Gloria, E. St. Louis	
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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 7 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>asthma</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Pulmonary emphysema</i> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Arteriosclerotic Heart Disease</i>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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)	
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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?	
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22. I hereby certify that I attended the deceased from 8-9-1955, to 8-14-1955, that I last saw the deceased alive on 8-14-1955 and that death occurred at 7 A. m., from the causes and on the date stated above.

23a. SIGNATURE <i>Ray Ortmeyer</i> (Degree or title)		23b. ADDRESS City Hospital		23c. DATE SIGNED 7/14/55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-15-1955		24c. NAME OF CEMETERY OR CREMATORY City Cemetery	
				24d. LOCATION (City, town, or county) (State) Hickman Kentucky	

DATE REC'D BY LOCAL REG. AUG 15 1955		REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin F.H., Inc., 2301 Lafayette	
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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.....
Signature of Student Embalmer

Signed..... *James R. Simpson*
Licensed Embalmer No..... *45*
P. O. Address..... *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.