

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10.48

FILED DEC 18 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10459**

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

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) St. Louis		c. LENGTH OF STAY (In this place) 1 mo.	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hosp.		e. STREET ADDRESS (If rural, give location) 23 1208 N. 8th St.	
3. NAME OF DECEASED (Type or Print) a. (First) Harry b. (Middle) Eugene c. (Last) Dowell		4. DATE OF DEATH (Month) (Day) (Year) Nov. 15 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 11-10-1880
9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 5	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Dentist	11. BIRTHPLACE (City and State or Foreign Country) Tuckerman Ark.
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Foster Dowell		13b. MOTHER'S MAIDEN NAME unk.	14. NAME OF HUSBAND OR WIFE Jane Taylor Dowell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. H. E. Dowell 1208 N. 8th St. Apt C.	
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) Antecedent Causes Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Generalized Arteriosclerosis DUE TO (b) 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 450.0	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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 10-24-56 19___, to 11-15-56 , 19___, that I last saw the deceased alive on 11-15-56 , 19___, and that death occurred at 7:50a m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) John Niederwieser, M.D.		23b. ADDRESS 5800 Arsenal St.	23c. DATE SIGNED 11-15-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 11/17/56	24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens	24d. LOCATION (City, town, or county) (State) St. Louis County Missouri
DATE REC'D BY LOCAL REG. NOV 16 1956		REGISTRAR'S SIGNATURE Carly Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ambruster Mortuary 6633 Clayton Road

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.....


Licensed Embalmer No. 4788

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.