

FILED OCT 31 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37438

STATE FILE NUMBER

Registration District No. ....

318

Primary Registration District No. ....

1003

Registrar's No. ....

9993

300  
1-57

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, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>1954a Arsenal St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MAE FOWLER</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>23</b> Year <b>1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 8, 1890</b>
9. AGE (In years last birthday) <b>67</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookbinder</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>William Horack</b>	13b. MOTHER'S MAIDEN NAME <b>Minnie Ender</b>
14. NAME OF HUSBAND OR WIFE <b>Walter Fowler (deceased)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>494-09-5323</b>
17. INFORMANT <b>Lillian Belter</b>		Address <b>1954a Arsenal St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Pneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (b) <b>331x</b>			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>10/13/57</b> to <b>10/23/57</b> and last saw her alive on <b>10/23/57</b> Death occurred at <b>8:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Joseph Drew Callahan MD</b>		(Degree or title)	22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>
22c. DATE SIGNED <b>10/23/57</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	
23b. DATE <b>10-26-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS Peter &amp; Paul Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Louis Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>Thomas Kutis</b>		ADDRESS <b>2906 Gravois Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 25 57</b>
26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 C. Hill

Licensed Embalmer No. 4377

P. O. Address 2906 ...

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.