

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58493-58
1003

58-030176
STATE FILE NUMBER
7488

FILED SEP 15 1958

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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v. 1-57
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1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Maplewood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) <u>Bethesda General Hospital.</u>		Length of stay in lb _____	d. STREET ADDRESS (If outside, give location) <u>7423 Commonwealth Av.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Samuel</u> Last <u>Bowers</u>			4. DATE OF DEATH Month <u>July</u> Day <u>29</u> , Year <u>1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1958</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours <u>2</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.A.</u>
13a. FATHER'S NAME <u>James Thomas Bowers</u>		13b. MOTHER'S MAIDEN NAME <u>Zelpha Maxine Dickey</u>		14. NAME OF HUSBAND OR WIFE <u>infant.</u>	
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 <u>JAMES BOWERS - 7423 COMMONWEALTH</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature Infant</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours 3 min</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____				776X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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 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 <u>July 29-1958</u> and last saw him alive on <u>July 29, 1958</u> Death occurred at <u>1:55 P.M. July 29, 1958</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Vincent J Townsend</u>			22b. ADDRESS <u>3101 Section Ave Maplewood Mo</u>		22c. DATE SIGNED <u>7-30-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>7-31-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HIGHLAND CEM</u>		23d. LOCATION (City, town, or county) (State) <u>HAMILTON MO</u>	
24. FUNERAL DIRECTOR <u>JAY. B-SMITH-Maplewood Mo</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 31 58</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, m.d.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *J. Allen James*
Licensed Embalmer No. *4053*
P. O. Address *W. L.*

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.