

Health,  
& Welfare  
Public  
Service

S. 300  
1-57

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.

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

58-034611  
STATE FILE NUMBER  
Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8762

FILED SEP 29 1958

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Ladue	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS 20 Lindworth Dr.	
3. NAME OF DECEASED (Type or print) First Middle Last Minnie Prowell		4. DATE OF DEATH Month Day Year 9 8 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 18, 1894
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. KIND OF BUSINESS OR INDUSTRY Home	9c. BIRTHPLACE (City and state or country) Mt. Carmel, Ill.
10a. FATHER'S NAME Charles H. Kolb		10b. MOTHER'S MAIDEN NAME Elizabeth Arntz	10c. NAME OF HUSBAND OR WIFE Oden D. Prowell
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No		12. SOCIAL SECURITY NO. none	13. INFORMANT Address Oden D. Prowell, 20 Lindworth Dr.
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STREPTOCOCCAL MENINGITIS			15. INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			340.2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHROMOPHOBE ADENOMA OF BRAIN 15-20 YEARS			16. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
17a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
18. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
19. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from AUG. 27, 1958 to SEPT. 8, 1958 and last saw her alive on SEPT. 8, 1958		22. CITY, TOWN, OR LOCATION COUNTY STATE	
Death occurred at 12:15 p m on the date stated above; and to the best of my knowledge, from the causes stated.			
23a. SIGNATURE (Signature or title) E. Vermillion, M.D.		23b. ADDRESS BARNES HOSPITAL	
23c. DATE SIGNED 9/9/58			
24. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 9/11/58	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
25. FUNERAL DIRECTOR ADDRESS Drehmann-Harral 1905 Union		26. DATE RECD. BY LOCAL REG. SEP 10 1958	
		27. REGISTRAR'S SIGNATURE J. Pearl Smith, M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Mr. J.B.

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 *Warren A. Carver* .....

Licensed Embalmer No. *353* .....

P. O. Address .....

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.