

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036889

STATE FILE NUMBER 39

FILED OCT 20 1958

Registration District No. 159 Primary Registration District No. 4249 Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jefferson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Hillsboro</b>		Inside Limits. Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cedar Grove Home</b>		Length of stay in 1b <b>1 day</b>	d. STREET ADDRESS (If outside, give location) <b>1843 Dolman Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>T</b> Last <b>Bowers</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>30</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8 1889</b>	9. AGE (In years birthday) <b>69</b>	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Work House</b>	11. BIRTHPLACE (City and state or country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S</b>
13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>Yes 1st</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Virginia T Schmidt 1843 Dolman Street</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) <u><b>Cerebrovascular Accident</b></u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>2 Wks</b>	
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 _____ a.m. _____ p.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u><b>9-29-58</b></u> to <u><b>9-30-58</b></u> and last saw <sup>her</sup> him alive on <u><b>9-29-58</b></u> Death occurred at <u><b>10:00 A.M.</b></u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u><b>John W Deake M.D.</b></u>			22b. ADDRESS <u><b>3606 Harris St. Louis</b></u>		22c. DATE SIGNED <u><b>10-1-58</b></u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Crementation</b>		23b. DATE <b>10/3/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>St Louis Missouri</b>
24. FUNERAL DIRECTOR <b>Moydell Funeral Home</b>		ADDRESS <b>1926 Allen</b>		25. DATE RECD. BY LOCAL REG. <b>10-2-58</b>	26. REGISTRAR'S SIGNATURE <u><b>Walter L. Gardner</b></u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JEFFERSON COUNTY HEALTH DEPT.  
MILLSBORO, MISSOURI

8961 12 100  
OCT 21 1958

DATE RECEIVED

OCT 7 1958

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 myself....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Reinhold K. Lehmann

Licensed Embalmer No. 3395

P. O. Address St. Louis 7 Mo

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.