

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041558

STATE FILE NUMBER

318

1003

Registrar's No. 10691

FILED NOV 21 1958

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE No. b. COUNTY <i>St. Louis</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Webster Grove</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>BARNES HOSPITAL</b>		Length of stay in lb.	d. STREET ADDRESS (If outside, give location) <b>704 Cornell</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES NMN FOWLER</b>			4. DATE OF DEATH Month Day Year <b>NOVEMBER 4, 1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</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>10-19-1881</b>	9. AGE (In years at birthday) <b>77</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Jantor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>	11. BIRTHPLACE (City and state or country) <b>South Point, Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13a. FATHER'S NAME <b>James Fowler</b>		13b. MOTHER'S MAIDEN NAME <b>UNK</b>		14. NAME OF HUSBAND OR WIFE <b>Decased</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>487-30-6310</b>		17. INFORMANT Address <b>Mrs Ruth James 201 Sherman</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>PERINEPHRIC ABSCESS</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>PERFORATED CARCINOMA OF DISSENDING COLON</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b>  <b>SEVERAL YRS.</b>
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.) <b>153.2</b>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <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 <b>OCT. 9, 1958</b> to <b>NOV. 4, 1958</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>NOV. 4, 1958</b> Death occurred at <b>1:10 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>C. O. Vermillion, M.D.</i>			22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>11/5/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>11-8-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Father Dickson Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crestwood Mo.</b>
24. FUNERAL DIRECTOR <b>Lewis Funeral Home</b>		ADDRESS <b>22 Euclid</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 7 '58</b>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MO</i> <b>m JB</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

*James A. Cart*

Licensed Embalmer No. ....

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P. O. Address .....

*D. 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.