

FILED JAN 12 1959

58-045661

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

SL 18319

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12597

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 915 N GRAND, ST LOUIS, MO.		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS ADM HOSPITAL		d. STREET ADDRESS (If outside, give location) 1861 S 13TH STREET	
Length of stay in lb 47 DAYS		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GUY T. FOWLER			4. DATE OF DEATH Month Day Year DECEMBER 27, 1958
5. SEX MALE 0	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 12/14/89
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STREET-CAR OPERATOR		9b. KIND OF BUSINESS OR INDUSTRY NONE	9c. AGE (In years last birthday) 69
10a. FATHER'S NAME JAMES T. FOWLER		10b. MOTHER'S MAIDEN NAME LELA THOMAS	10c. NAME OF HUSBAND OR WIFE FRIEDA FOWLER
11. BIRTHPLACE (City and state or country) AROCK, MISSOURI 0		12. CITIZEN OF WHAT COUNTRY? USA	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		14. SOCIAL SECURITY NO. UNKNOWN	15. INFORMANT VA HOSP RECORDS 915 N GRAND ST LOUIS MO
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE CEREBRAL THROMBOSES DUE TO (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) 332x 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 6 MONTHS UNKNOWN
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. CITY, TOWN, OR LOCATION COUNTY STATE
22. ATTENDED THE DECEASED FROM 11-10-58, to and last saw him alive on 12/27/58		Death occurred at 5:15 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE V.A. CODIGA (Degree or title) M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 12/27/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/30/58	23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	23d. LOCATION (City, town, or county) (State) St Louis 23 Missouri
24. FUNERAL DIRECTOR Moydell Funeral Home 1926 Allen		25. DATE RECD. BY LOCAL REG. DEC 29 58	26. REGISTRAR'S SIGNATURE Carl Smith MO

(Licensed Embalmer's Statement on Reverse Side)

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 *Reinhold K. Lohman*

Licensed Embalmer No. *3395*
P. O. Address *St. Louis*

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.