Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002880
STATE FILE NUMBER
2 542

FILED FEB 3 1959

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

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Chronic Hosp. — Length of stay in Ib: 1 yr. 10 mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY:
c. CITY OR TOWN: 2219 Mm. St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3127 Thomas — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Rosie — Middle: — Last: Dowkins

4. DATE OF DEATH: Month — Day — Year: 1-13-59

5. SEX: Female

6. COLOR OR RACE: col. 3

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 7, 1888

9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (City and state or country): Ark.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Jerry Dowkins

13b. MOTHER'S MAIDEN NAME: Winnie Fowler

14. NAME OF HUSBAND OR WIFE: Oscar Nunn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Althea Brown — Address: 2141 Division Apt. 203

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 491X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Parkinson's Syndrome — 2 yrs.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 3-13-57, to 1-13-59 and last saw her/him alive on 1-13-59
Death occurred at 12:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John W. Beckham, M.D.
22b. ADDRESS: 5800 Arsenal
22c. DATE SIGNED: 1/14/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan. 20, 1959
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: E.B. Koonce — **ADDRESS**: 1221 N. Grand Blvd.

25. DATE RECD. BY LOCAL REG.: JAN 16 '59

26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Licensed Embalmer No. 475

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.