

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014723

FILED MAY 15 1959

STATE FILE NUMBER 2 4044
Registration No. 4044

Registration District No. _____ Primary Registration District No. _____

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|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Berkley 4041 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital | | Length of stay in lb. 12 hrs. | d. STREET ADDRESS (If outside, give location) 5850 Dowling | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Ann Last Bowie | | | 4. DATE OF DEATH Month April Day 22 Year 1959 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 1, 1895 | 9. AGE (In years birthday) 63 | IF UNDER 1 YEAR Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Macoupin Co., Ill. | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13a. FATHER'S NAME James B. Vandergriff | | 13b. MOTHER'S MAIDEN NAME Mary J. McCullough | | 14. NAME OF HUSBAND OR WIFE Harry W. Bowie | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT Address Harriett Hizon, 5850 Dowling | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. Conditions, if any, which give rise to above cause (a), stating the underlying cause last Hypertensive Cardiovascular Disease DUE TO (b) 443x DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 18 mos | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | |
| 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. Month, Day, Year _____ | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 4-22-59 , to 4-22-59 and last saw her alive on 4-22-59 Death occurred at 4:05 pm m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Alphonse McMahon, M.D. | | | 22b. ADDRESS 634 N. Grand' Blvd | | 22c. DATE SIGNED 4-24-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 4-25-59 | 23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery | | 23d. LOCATION (City, town, or county) (State) Carrollton, Ill. |
| 24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd. | | 25. DATE RECEIVED BY HEALTH REG. APR 24 59 | | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D., P.P. | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Att. diseases in this part 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 *Harvey Kable*

Licensed Embalmer No. *4596*
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.