

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018966

STATE FILE NUMBER 2
REGISTRATION DISTRICT NO. 4912

FILED JUN 4 1959

Registration District No. Primary Registration District No.

Registrar 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 Dent | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Salem Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) Route 2 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Grover Middle C. Last Bowen | | | 4. DATE OF DEATH Month May Day 20 Year 1959 |
| 5. SEX Male | 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 April 2, 1893 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 9b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years at birthday) 66 IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Lake Springs, Mo. |
| 13a. FATHER'S NAME George Bowen | | 13b. MOTHER'S MAIDEN NAME Elmira Huskey | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 14. NAME OF HUSBAND OR WIFE Alpha Bowen | | 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. 489-16-0878 | | 17. INFORMANT Address Alpha Bowen, Salem, Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriolar Nephrosclerosis DUE TO (c) +42X | | | INTERVAL BETWEEN ONSET AND DEATH 9 days ? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic cardiovascular disease | | | 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.) ITEM 22c CORRECTED | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | BY AFFIDAVIT OF Physician 6-29-59 | |
| 20d. INJURY OCCURRED WHILE AT <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 5-12-59 to 5-20-59 and last saw her alive on 5-19-59 Death occurred at 1:30 am m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) C. E. Mueller, M.D. | | 22b. ADDRESS 634 N. Grand Blvd. | |
| 22c. DATE SIGNED 5/20/59 | | 22d. ADDRESS (City, town, or county) (State) Dent Co., Mo. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 4-22-59 | |
| 23c. NAME OF CEMETERY OR CREMATORY Morrison Cemetery | | 23d. LOCATION (City, town, or county) (State) Dent Co., Mo. | |
| 24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd. | | 25. DATE RECD. BY LOCAL REG. MAY 20 1959 | |
| 26. REGISTRAR'S SIGNATURE Dr. B. Carl Smith, M.D. | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Stanley F. Airon*
Licensed Embalmer No. *4193*
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.