

XC-1232 207

SL 20001

FILED JUN 18 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022714

STATE FILE NUMBER

Registration No. 2 5485

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.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		Length of stay in 1b 19 days	d. STREET ADDRESS (If outside, give location) 2900 LOUISIANA Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First DAVID Middle E. Last BOWEN			4. DATE OF DEATH Month JUNE Day 7 Year 1959		
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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 5/23/98	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE FITTER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ADA, MINNESOTA	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME GEORGE BOWEN	13b. MOTHER'S MAIDEN NAME BERTHA JANIS	14. NAME OF HUSBAND OR WIFE ELVA BOWEN
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1	16. SOCIAL SECURITY NO. 497-05-5080	17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 3 YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	420.0
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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
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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
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21. attended the deceased from 5/19/59 to 6/7/59 and last saw <input checked="" type="checkbox"/> him alive on 6/7/59 Death occurred at 3:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE V. A. Codiga <i>V. A. Codiga</i> (Degree or title) M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 6/7/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE JUNE 10 1959	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) JEFFERSON BARRACKS MO
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24. FUNERAL DIRECTOR Thomas Kurtis ADDRESS 2906 Gravois	25. DATE RECD. BY LOCAL REG. JUN 9 '59	26. REGISTRAR'S SIGNATURE <i>Earl Smith. M.D.</i>
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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 C. Hill

Licensed Embalmer No. 4347
P. O. Address 2916 1/2 Ave

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.