

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023698

FILED JUN 26 1959 Registration District No. 317 Primary Registration District No. 500 STATE FILE NUMBER 1568 Registrar's No.

1. PLACE OF DEATH a. COUNTY St. Louis		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 Normandy		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteopathic		Length of stay in lb 26 HRS.	
3. NAME OF DECEASED (Type or print) First Middle Last Bowie		4. DATE OF DEATH Month Day Year 6 7 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 0
11. BIRTHPLACE (City and state or country) Normandy, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Elroy Bowie		13b. MOTHER'S MAIDEN NAME Marcella Lou Kenner	
14. NAME OF HUSBAND OR WIFE -----		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Marcella Lou Bowie 4240 Castleman	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure prematurity Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) 7735.			INTERVAL BETWEEN ONSET AND DEATH 1 day
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? 1 YES <input type="checkbox"/> NO <input 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.)	
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	
21. I attended the deceased from 6-6-59 to 6-7-59 and last saw ^{her} / _{him} alive on 6-7-59 Death occurred at 9:13 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Dee or title) Mary Richardson D.O.		22b. ADDRESS 2335 Brown Road Overland 11	
22c. DATE SIGNED 6-9-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 9, 1959	
23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cem.		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
24. FUNERAL DIRECTOR Kriegshauser 4228 S.Kingshighway		25. DATE RECD. BY LOCAL REG. 6-9-59	
26. REGISTRAR'S SIGNATURE John C. Murphy 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 *Richard H. Stovessand*

Licensed Embalmer No. *4007*

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.