

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026430

FILED VS JUL 24 1959

Registration District No.

Primary Registration District No.

Registration No.

2 6487

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution/Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>220 N. Kingshighway</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>220 N. Kingshighway</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>STONE</b> Last <b>BOWMAN</b>				4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>1959</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>3/10/1872</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None -</b>		11. BIRTHPLACE (City and state or country) <b>Spencer Co., Kentucky</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A. -</b>	
13a. FATHER'S NAME <b>Jesse Stone</b>			13b. MOTHER'S MAIDEN NAME <b>Kate Bodine</b>			14. NAME OF HUSBAND OR WIFE <b>D. Howard Bowman</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No none</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>1058 - 32nd Street South.</b> <b>Mrs. V. William Borntraeger</b> Address <b>Birmingham Ala.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of colon</b> DUE TO (b) _____ DUE TO (c) <b>153.8</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arterioscl heart disease</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 <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 <b>April 2, 1940</b> to <b>July 8, 1959</b> and last saw her/him alive on <b>July 8, 1959</b> Death occurred at <b>1:45 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>John L. Horner MD</b> (Degree or title)				22b. ADDRESS <b>114 N. Taylor St. St Louis 8 Mo</b>			22c. DATE SIGNED <b>7-9-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>July 10, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cave Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Louisville, Kentucky</b>				
24. FUNERAL DIRECTOR <b>C.R. Lupton and Sons</b>			ADDRESS <b>7233 Delmar Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 9 '59</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Handwritten initials*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Clarence H. Murray

Licensed Embalmer No. 4011

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.