

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028701

FILED VS. SEP 14 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 943

STATE FILE NUMBER

| | | | | | | | |
|---|----------------------------------|---|---|--|--|--|-----------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY GREENE | | b. CITY (If outside corporate limits, give TOWNSHIP only) Springfield | | a. STATE Michigan | | b. COUNTY Mt. Clemens | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Medical Center for Federal Prisoners | | Length of stay in 1b 3 1/2 Hours | | c. CITY OR TOWN Mt. Clemens | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. STREET ADDRESS 4255 N. Walnut St. | | e. INSIDE LIMITS Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First Carl | | Middle Nelson | | Last Bowling | | Month Day Year September 5 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 Unknown | 9. AGE (last birthday) 27 | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (City and state or country) Boyd County, Kentucky | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Clyde Bowling | | | 13b. MOTHER'S MAIDEN NAME Midge Blankenshop | | | 14. NAME OF HUSBAND OR WIFE Vallrie Crowley Bowling | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1951 to 1958 | | | 16. SOCIAL SECURITY NO. 284 32 3465 | | 17. INFORMANT MCFP Files | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Cerebral edema | | | | | | 10 days | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Glioma of brain, left frontal lobe with extens- | | | | | | | |
| DUE TO (c) ion to right frontal lobe | | | | | | 6 Months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 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 Sept. 4, 1959 to Sept. 5, 1959 and last saw ^{HE} _{HER} alive on 9:45 P.M. 9/5/59 Death occurred at 9:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) J. A. Hunt, M.D. | | | | 22b. ADDRESS Medical Center For Clinical Director Federal Prisoners - Springfield | | | 22c. DATE SIGNED 9/7/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE Sept 8, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Cateburg, Kentucky | | 23d. LOCATION (City, town, or county) (State) Kentucky | | |
| 24. FUNERAL DIRECTOR Awre-Goodwin Springfield, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 9-11-59 | | 26. REGISTRAR'S SIGNATURE Effie S. Melton | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 7 1961

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 Harry Payne

Licensed Embalmer No. 4594

P. O. Address Springfield,

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.