

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007969

FILED VS FEB 25 1960

2 1804

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4360 Washington Ave.
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) EMMA Middle BOW Last		4. DATE OF DEATH FEB. Month 12 Day 1960 Year	
---	--	---	--

5. SEX Female	6. COLOR OR RACE Col.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/23/1910	9. AGE (last birthday) 49	IF UNDER 1 YEAR Months 6 Days 29	IF UNDER 24 HR Hours _____ Min. _____
-------------------------	---------------------------------	---	--------------------------------------	-------------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Ypselante, Mich.	12. CITIZEN OF WHAT COUNTRY USA.
---	-----------------------------------	---	--

13a. FATHER'S NAME George Robb	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Ray Bow
--	---	---

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. _____	17. INFORMANT Address James Bow 2602 A. Chouteau Ave.
--	----------------------------------	---

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) Mucous Oesophagus - tracheobronchitis		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Spontaneous cell carcinoma of the stomach - metastatic spread - op.	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 143x		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 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 **1/13/60** to **2/12/60** and last saw ^{her}/_{him} alive on **2/12/60**
Death occurred at **7:00 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph J. Palta M.D.	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 2/13/60
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/19/60	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
--	-----------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS Wright Funeral Home 3100 Easton Ave.	25. DATE RECD. BY LOCAL REG. FEB 16 1960	26. REGISTRAR'S SIGNATURE Keon Smith M.D.
---	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

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.