

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035282

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Registration District No. 367 Primary Registration District No. 500 Registrar's No. 7600

**FILED SEP 27 1961**

1. PLACE OF DEATH a. COUNTY <b>Saint Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saint Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lemay (25)</b>		c. CITY OR TOWN <b>Lemay (25)</b>	
Length of stay in 1b <b>14 Years</b>		Inside Limits <b>Yes</b> <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>719 Horn Ave.</b>		d. STREET ADDRESS (If outside, give location) <b>719 Horn Ave.</b>	
Inside Limits <b>Yes</b> <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <b>Yes</b> <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHESTER GOWENS</b>			4. DATE OF DEATH Month Day Year <b>Sept. 15, 1961</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/25/07</b>
9. AGE (last birthday) <b>54</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>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Mountain View, Ark.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Newton Owen Gowens</b>	
13b. MOTHER'S MAIDEN NAME <b>Alberta Simpson</b>		14. NAME OF HUSBAND OR WIFE <b>Hattie Gowens</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>		17. INFORMANT Address <b>Hattie Gowens 719 Horn Ave. (25)</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>Uremia and Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Scleroderma involving the lungs, 1 yr</b>			
DUE TO (c) <b>Kidney, Extremities</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Glomerulonephritis 2° to GU Catheter</b>			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 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.)	
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>Aug 29 1961</b> to <b>Sept 15</b> and last saw her/him alive on <b>Sept 14 1961</b> Death occurred at <b>5:00 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Donald R. Moore, MD</b>		22b. ADDRESS <b>Jewish Hospital, St Louis</b>	22c. DATE SIGNED <b>Sept 16 1961</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Sept. 18, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Case Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Mountain View, Arkansas.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Fendler Und.Co. 7420 Michigan Ave. (11)</b>	25. DATE RECD. BY LOCAL REG. <b>9-16-61</b>	26. REGISTRAR'S SIGNATURE <b>John B. Mumfry, M.D.</b>	

Dr. Donald S. Mason  
9334 Berry Ave  
No-1-6346

**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 W E Morris

Licensed Embalmer No. 3360

P. O. Address St Louis, Mo

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.