SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-038915
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10291

FILED NOV 10 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b D.O.A.

c. CITY OR TOWN Lemay (25) — Inside Limits Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Lutheran Hospital — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 731 Cumberland Ave — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Earl Middle Last McDowell

4. DATE OF DEATH Month Day Year 11-4-1961

5. SEX Male

6. COLOR OR RACE White

7. Married ☒ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 1-23-1912

9. AGE (last birthday) 49 Yrs — 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) Electrican

10b. KIND OF BUSINESS OR INDUSTRY Monsanto Chem Co

11. BIRTHPLACE (City and state or country) Fredericktown Mo

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Samuel D. McDowell

13b. MOTHER'S MAIDEN NAME Carrge Howell

14. NAME OF HUSBAND OR WIFE Marie McDowell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.#2

17. INFORMANT Address Arvalle Harris Flat River Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH 2 HRS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) CORONARY OCCLUSION

DUE TO (c) 420.1

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐

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 May 61, to Oct 61 and last saw ~~her~~ him alive on Oct 17 61

Death occurred at 4:55 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Leo Munko MD

22b. ADDRESS 1900 Telegraph (25)

22c. DATE SIGNED 10-6-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 11-7-1961

23c. NAME OF CEMETERY OR CREMATORY St. Francois Cemetery

23d. LOCATION (City, town, or county) St. Francois Co (State) Mo

24. FUNERAL DIRECTOR ADDRESS Fendler Und. Co. 7420 Michigan Ave. (11)

25. DATE RECD. BY LOCAL REG. NOV 6 1961

26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

JAN 30 1962

1900 Telegraph
T.W. 2-6233

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. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Mich

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.