SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-039450
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3125

FILED NOV 15 1961

1. PLACE OF DEATH
a. COUNTY: St.Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Pine Lawn
Length of stay in 1b: 24 yrs.
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 3804 Council Grove
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St.Louis
c. CITY OR TOWN: Pine Lawn
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3804 Council Grove
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: John Middle: Henry Last: Bowen
4. DATE OF DEATH: Month: November Day: 6, Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 4/15/1878
9. AGE (last birthday): 83
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): Retired Material Handler
10b. KIND OF BUSINESS OR INDUSTRY: Carter Carburetor
11. BIRTHPLACE (City and state or country): Sue City, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Green Bowen
13b. MOTHER'S MAIDEN NAME: Nancy Wilson
14. NAME OF HUSBAND OR WIFE: Jennie Bowen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Willard Bowen, 8817 Greenbrook Dr. Address

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): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): ACHD — years
DUE TO (c):
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 2/28/59, to 11/6/61 and last saw him alive on 10/9/61
Death occurred at 3:15 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert A. Bauer MD
22b. ADDRESS: Northland Med Bldg
22c. DATE SIGNED: 11/6/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11-9-61
23c. NAME OF CEMETERY OR CREMATORY: Locust Hill Cemetery
23d. LOCATION (City, town, or county) (State): Novelty, Mo.

24. FUNERAL DIRECTOR ADDRESS: Hudson-Rimer Funeral Home, Edina, Mo.
25. DATE RECD. BY LOCAL REG.: 11-6-61
26. REGISTRAR'S SIGNATURE: John C. Wingfield M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

VS NOV 15 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 me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. L.

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.