

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-042290  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11179

FILED DEC 12 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		a. STATE <b>MISSOURI</b> COUNTY <b>ST LOUIS,</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>EARNES HOSPITAL</b>		c. CITY OR TOWN <b>VINITA PARK</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>2132 NORTH &amp; SOUTH RD</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
<b>EUGENE</b>	<b>O.</b>	<b>COWGILL</b>		<b>NOVEMBER</b>	<b>30</b>	<b>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>10/11/1906</b>	9. AGE (last birthday) <b>55</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
-----------------------	----------------------------------	---	---------------------------------------	-------------------------------------	---------------------------	------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SERVICEMAN</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>VICTOR ADDING MACHINE CO.</b>	11. BIRTHPLACE (City and state or country) <b>ST LOUIS MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
--	---	---	--

13a. FATHER'S NAME <b>WILLIAM E. COWGILL</b>	13b. MOTHER'S MAIDEN NAME <b>CATHERINE TWELBECK</b>	14. NAME OF HUSBAND OR WIFE <b>IRENE</b>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	17. INFORMANT <b>IRENE COWGILL</b>	Address <b>2132 NORTH &amp; SOUTH</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>BRONCHOGENIC CARCINOMA OF LEFT LUNG</b>	INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL MOS.</b>
--	---

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

DUE TO (b) \_\_\_\_\_

DUE TO (c) \_\_\_\_\_

**1621F**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>PATHOLOGIC FRACTURE OF RIGHT FEMUR</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>JUNE 25, 1961</b> to <b>NOV. 30, 1961</b> and last saw her/him alive on <b>NOV. 30, 1961</b> Death occurred at <b>6:50 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <i>E. O. Vermillion, M.D.</i>	(Degree or title) <b>M. D.</b>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>11/30/61</b>
---	-----------------------------------	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>12/2/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LAKE CHARLES CEMETERY</b>	23d. LOCATION (City, town, or county) <b>ST LOUIS MISSOURI</b>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR <b>STROOT - CARROLL</b>	ADDRESS <b>4600 NAT'L BRIDGE</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 1 1961</b>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
---	-------------------------------------	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*OK  
Account  
Covered  
12-1-61*

**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 M W Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis

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.