

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-81-047120
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3468

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | |
|--|---|--|--|--|---------------------------------|
| FILED DEC 18 1961 1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS COUNTY</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis Co.</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BERKLEY</u> | | Length of stay in 1b <u>6 YR</u> | c. CITY OR TOWN <u>University City</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>EDGEWOOD HOSPITAL</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>6823 Etzel, Ave.</u> | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>M</u> Last <u>COWMAN</u> | | | 4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>61</u> | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/30/1880</u> | 9. AGE (last birthday) <u>81</u> | |
| 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) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (City and state or country) <u>Coulterville, Illinois.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>John Kennedy</u> | | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Neil</u> | | 14. NAME OF HUSBAND OR WIFE <u>Ben F. Cowman</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>Nil.</u> | 17. INFORMANT Address <u>W. Walter Kennedy, 6821 Etzel, Ave.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Rt lower lobe</u> DUE TO (b) <u>also arteriosclerotic Cardio-Vascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | INTERVAL BETWEEN ONSET AND DEATH <u>45 days</u> <u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>op) with probable metastases</u> | | | 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 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 <u>Sept 6 1961</u> to <u>Dec 7, 1961</u> and last saw her alive on <u>Dec 7 1961</u> Death occurred at <u>10:00 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Joseph P. Keadis, MD</u> | | | 22b. ADDRESS <u>462 N. Taylor Ave St. Louis 8 Mo</u> | | 22c. DATE SIGNED <u>12/7/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>12-9-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Coulterville Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Coulterville, Illinois.</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe Inc., 4700 Washington, Blvd.</u> | | 25. DATE RECD. BY LOCAL REG. <u>12-8-61</u> | 26. REGISTRAR'S SIGNATURE <u>J. M. Murphy, M.D.</u> | | |

NOV 15 1962

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 Melvin L. Kemper

Licensed Embalmer No. 4052

P. O. Address 4911 Wash

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.