

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-003052

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 4

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>FILED - JAN 18 1963</b>	
<p>1. PLACE OF DEATH a. COUNTY <u>St. Charles</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u> Length of stay in 1b <u>65 Yrs.</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Charles</u></p> <p>c. CITY OR TOWN <u>St. Charles</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>507 Lindenwood Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED First <u>Leo</u> Middle <u>Joseph</u> Last <u>Bowles</u></p>	
<p>4. DATE OF DEATH Month <u>Jan.</u> Day <u>4,</u> Year <u>1963</u></p>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31, 1879</u>
9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months <u>2</u> Days <u>3</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical Construction</u>
11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Silas Bowles</u>	13b. MOTHER'S MAIDEN NAME <u>Ann E. Mudd</u>
14. NAME OF HUSBAND OR WIFE <u>Mary Florence Bowles</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>[REDACTED]</u>
17. INFORMANT Address <u>Mrs. Mary Bowles, St. Charles, Mo.</u>	
<p>18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u></p> <p style="text-align: center;">DUE TO (b) <u>Cerebral arteriosclerosis</u></p> <p style="text-align: center;">DUE TO (c) <u></u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>	
<p>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</p>	
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 <u></u> Month, Day, Year <u></u>	
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>Feb 1, 1961</u> to <u>Jan 4, 1963</u> and last saw <sup>her</sup> him alive on <u>Jan 4, 1963</u> Death occurred at <u>8:10</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Eugene J. Cowdy, M.D.</u>	22b. ADDRESS <u>St. Charles, Mo.</u>
22c. DATE SIGNED <u>Jan 7, 1963</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Eurial</u>	23b. DATE <u>Jan. 8, 1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Charles, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>H.C. Dallmeyer &amp; Sons, St. Charles, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Jan 7, 1963</u>
26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>	

USE BLACK INK OR TYPEWRITER RIBBON

JUN 24 1966

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**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 Charles F. Macke

Licensed Embalmer No. 4536

P. O. Address St. Charles, 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.