

Registration District No.

791  
1003

Primary Registration District No.

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Deaconess Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 Days  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME James R. Fowler H.W.C.3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 492-07-87664. Sex Male 5. Color or race White 6. (a) ~~Single, widowed, married,~~ Married6. (b) Name of ~~husband's~~ wife Jane Fowler 6. (c) Age of ~~husband's~~ wife 67 years7. Birth date of deceased April 23, 1874  
(Month) (Day) (Year)8. AGE: Years 65 Months 4 Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace England  
(City, town, or county) (State or foreign country)10. Usual occupation Foreman Graham Paper Co.

11. Industry or business \_\_\_\_\_

12. Name Dont know13. Birthplace England  
(City, town, or county) (State or foreign country)14. Maiden name Dont know15. Birthplace England  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mr Arthur Fowler(b) Address 5202 Alabama Ave.17. (a) Burial (b) Date thereof 8-28-1939  
(Burial, ~~community~~) (Month) (Day) (Year)(c) Place: burial Laurel Hill Cemetery18. (a) Signature of funeral director Geo. L. Pleitsch Inc.(b) Address 5966-68 Easton Ave.19. (a) AUG 28 1939 (b) J. D. [Signature]  
(Date received local registrar) (Registrar's Signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
 (c) City or town Wellston NR  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 6755 Lillie Ave.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 36 years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25th  
6 year 1939 hour 1 minute 15 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediately cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Septicemia following ruptured appendix

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_ Of operations \_\_\_\_\_

Of autopsy See above

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically. X

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? U

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Alfred Perry (M. D. or other) \_\_\_\_\_Address Alfred Perry Date signed 8-28-39

**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 3454

David C. Gibson

Registered Apprentice No.

working under my personal supervision.

Signed

David C. Gibson

Licensed Embalmer No. 3454

P. O. Address

**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 this body is not embalmed, above space should be left blank.**