

Registration District No.

1003

Primary Registration District No.

Registrar's No.

8004

## 1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: City Hospital /  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Day  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME Joseph H. Bowman 5503. (b) If veteran, \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
name war \_\_\_\_\_4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widower6. (b) Name of husband or wife Lillie 6. (c) Age of husband or wife if alive \_\_\_\_\_ years7. Birth date of deceased Unknown  
(Month) (Day) (Year)8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
About 75 hr. \_\_\_\_\_ min.9. Birthplace Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Labor 11. Industry or business Retired12. Name unk 13. Birthplace 4  
(City, town, or county) (State or foreign country)14. Maiden name 4 15. Birthplace 4  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Joe Quinlan(b) Address Coroners Office17. (a) Burial (b) Date thereof September 18 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Memorial Park18. (a) Signature of funeral director Peetz Brothers(b) Address 3029 Lafayette Ave19. (a) SFD 17 1939  
(Date received local registrar) (Signature of registrar)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis 35  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 112 1/2 N. 6th. St  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12th  
year 1939 hour 4:10 minute 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.Immediate cause of death Chronic Myocarditis;  
Arterio Sclerosis;

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

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

Other conditions [Signature]  
(Includes pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_23. Signature [Signature] (M. D. or other) \_\_\_\_\_Address \_\_\_\_\_ Date signed 9/16 39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Not Embalmed*

Licensed Embalmer No.....

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.**