

E16205

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5057
Registrar's No. 1887

Registration District No. 791 Primary Registration District No. 1003

FILED MAR 12 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days
In this community 3 DAYS (Specify whether years, months or days)

8. (a) PRINT FULL NAME Baby Bowers

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race W 6. (e) Single, widowed, married, divorced CHILD

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 2 21 40
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 2 If less than one day _____ hr. _____ min.

9. Birthplace ST. LOUIS MO.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name EDWARD BOWERS
18. Birthplace OWENS BORO KY
(City, town, or county) (State or foreign country)
14. Maiden name FRIEDA HILL
15. Birthplace ST. LOUIS MO
(City, town, or county) (State or foreign country)

16. (a) Informant Ed Bowers
(b) Address 2226 Bremen

17. (a) BURIAL (b) Date thereof 2/24/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FRIEDENS CEM

18. (a) Signature of funeral director [Signature]

(b) Address FEB 24 1940

19. (a) _____ (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County _____
(c) City or town ST. LOUIS 20
(If outside city or town limits, write "RURAL")
(d) Street No. 2226 BREMEN
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February, day 23,
year 1940 hour 9:00 minute A. M.

21. I hereby certify that I attended the deceased from February
21, 1940, to February 23, 1940;
that I last saw him alive on February 23, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Duration _____

Due to _____

Due to _____

Other conditions [Signature]
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) Manner of injury _____

23. Signature John F. Flynn Date signed 2/23/40
Address 1515 Lafayette

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.....

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.