

MAY 15 1940
791
Registration District No. _____

Primary Registration District No. _____

Registrar's No. **3588**

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:
St. Anthony's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME **Clarence Bowlby 410**

3. (b) If veteran, name war **No.** 8. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Blanche** 6. (c) Age of husband or wife if alive **?** years

7. Birth date of deceased **May 9 1889**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 11 10 hr. min.

9. Birthplace **Kankakee Co. Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Salesman**

11. Industry or business _____

MOTHER FATHER { 12. Name **Norman Bowlby**

13. Birthplace **Kankakee Co. Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Julia Anderson**

15. Birthplace **Kankakee Co. Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lester Bowlby**

(b) Address **5981 Hamilton Terrace**

17. (a) **Removal** (b) Date thereof **4-20-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellflower, Mo.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Ave.**

19. (a) **APR 20 1940** (b) _____
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis 17**
(If outside city or town limits, write "RURAL")
(d) Street No. **3551 Victor St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **19th**
year **1940** hour **9:30** minute _____ M.

21. I hereby certify that I attended the deceased from **April 16th** 19**40** to **April 19** 19**40**
that I last saw him alive on **April 19th** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **Autopsy shows massive subdural hemorrhage**

Due to **R. side of Brain**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: **Subdural Hemorrhage**

Of operations _____

Of autopsy **Subdural Hemorrhage**

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) Means of Injury _____

23. Signature **Burton Bohanna** (M. D. or other) _____

Address **2607 S. Grand** Date signed **4-20-40**

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

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

Guy W. Wilkiner

Licensed Embalmer No.

3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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